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February 11, 2019

Roger Severino

Director

Office of Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Washington, DC 20201

**Request for Information on Modifying HIPAA Rules to Improve Coordinated Care  
(Docket HHS-OCR-0945)**

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Saul Levin, M.D., M.P.A.

*CEO and Medical Director*

Dear Director Severino,

The American Psychiatric Association (APA), the national medical specialty society representing more than 37,800 psychiatric physicians, appreciates the opportunity to submit comments on the Department of Health and Human Services' Office of Civil Rights' request for information on how the HIPAA Privacy Rule could be modified to promote coordinated, value-based healthcare. APA advocates for strong privacy protections for patients given the sensitivity of their information and how it may be used. We also recognize that the need for privacy must be balanced with the importance of modernizing regulations to allow for more widespread use of effective integrated care models and collaboration between providers to improve health outcomes.

Currently, care for patients with mental health and substance use disorder conditions is fragmented, which creates challenges in meeting the whole health needs of the patient. Mental health and substance use disorders (MH/SUD) are often chronic conditions that people experience with other health conditions, such as heart disease and diabetes.<sup>1,2,3</sup> Patients with severe mental illness die years earlier than the general population, and the majority of these excess deaths are due to general medical conditions.<sup>1</sup> A growing body of research shows coordinated medical care can improve health outcomes,<sup>4</sup> but providers may be resistant to sharing the information of mental health patients due to confusion surrounding HIPAA laws. In addition, more stringent requirements are in place for the sharing of certain substance use disorder records that make it difficult for patients with

<sup>1</sup> Parks J, Svendsen D, Singer P, Foti ME: Morbidity and mortality in people with serious mental illness. NASMHPD. Alexandria VA 2006

<sup>2</sup> Walker ER, McGee RE, Druss BG: Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis. JAMA Psychiatry 2015; 72(4):334-41

<sup>3</sup> De Hert M, Correll CU, Bobes J, et al: Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. World Psychiatry Feb 2011; 10(1):52-77

<sup>4</sup> Gerrity M, Zoller E, Pinson N, et al: Integrating primary care into behavioral health settings: What works for individuals with serious mental illness. Milbank Memorial Fund December 17, 2014

substance use disorders to benefit from high-quality, coordinated care models. Below are our specific recommendations to improve incentives for information sharing and optimize care for all patients.

### Promoting Information Sharing for Treatment and Care Coordination

HIPAA is often interpreted more strictly than intended. Providers refuse to share information due to incorrect advice given to them by their legal team or for fear of being out of compliance with HIPAA, even when sharing information would be allowed by current law. Specific examples of when providers refuse to share information when requested include:

- A patient is experiencing a clinical emergency and information is sought from another provider about the patient's recent behavior or past history in order to conduct a thorough assessment;
- If a patient is transitioning from one level of care to another and information needs to be shared to coordinate care; or
- A provider, who referred a patient, calls to confirm that the patient kept a scheduled appointment.

The Department of Health and Human Services' Office of Civil Rights released helpful clarifying guidance in December 2017 about situations in which mental health information can be shared. ***We recommend DHHS OCR continue to share scenarios in which information sharing is allowed. We also recommend revising the current regulations to include a specific provision that would "hold harmless" providers who release information to other providers for treatment-related purposes. This would incentivize coordination between providers and reinforce the law's authorization of sharing information for treatment purposes.***

For providers who refuse to share information when requested, ***we recommend the declining provider or entity send a notice conveying their decision and why information is not being shared.*** A verbal decision should be given as soon as possible, with a written notice sent within seven days or 48 hours in emergency situations. Currently, providers may not receive a response from another entity to a request for sharing patient information, which makes it difficult for providers to develop a patient's treatment plan and could pose a threat to patient safety.

Lastly, we support sharing necessary patient information to truly coordinate care with social service agencies and community-based support programs. People with mental health problems often need a range of services associated with these programs, including housing, employment, and other community-based services. However, there should be caution in the amount of information shared to protect patient privacy. For example, if someone is going to live at a community residence that is administering and supervising medications, or helping the patient get their prescriptions from the pharmacy and get to appointments, the needed information is likely to be different than for a supported employment program if the patient's condition is essentially stabilized and they are taking medications independently. Encouraging greater adoption of electronic health records and the use of secure information exchange

among mental health, substance use, and community providers, would allow better information sharing in these care scenarios.

### Promoting Family and Caregiver Involvement and Addressing the Opioid Crisis and Serious Mental Illness

Family members, friends, and other individuals involved in the patient's support network can be important sources of collateral information about the reason for an evaluation, the patient's past history, and current symptoms and behavior.<sup>5</sup> They may also be an important component of a patient's care team. For example, in Coordinated Specialty Care (CSC), an evidence-based model used to treat people with first episode psychosis, family education and support are key components of the model. Specifically, family members are actively involved with the treatment and work collaboratively with the patient to identify their treatment milestones with an overall goal of improved patient outcomes. Patients who received treatment under CSC achieved significant improvements in education and employment and experienced a decrease in hospitalization rates.<sup>6</sup> ***We support rulemaking that would encourage covered entities to share protected health information, when appropriate, with family members, caregivers, and others who are in a position to avert threats of harm and other potential detriments to patients' health and safety, as well as to promote health and recovery.***

### Accounting of Disclosures

The APA is supportive of the components of the HITECH Act that would require a complete accounting of disclosures for treatment, payment, and health care operations (TPO) from an electronic health record (EHR) in a manner that provides helpful information to individuals, while minimizing regulatory burdens and disincentives to the adoption and use of interoperable EHRs. How these statutory requirements are interpreted through the lens of HIPAA and implemented into EHR systems are especially important for psychiatrists and their patients. For instance, some providers may inappropriately believe that psychiatric medical records in general receive additional protections within HIPAA, leading them to misinterpret other providers' and patients' use and disclosure of certain records as inappropriate or even illegal.

Furthermore, there are additional HIPAA protections around psychotherapy notes. Some software systems fail to clearly designate progress note versus psychotherapy note fields, which may result in psychotherapy notes being input into an incorrect part of the record (e.g., into the patient history field;

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<sup>5</sup> The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults, Third Edition. July 2015

<sup>6</sup> **Results of a Coordinated Specialty Care Program for Early Psychosis and Predictors of Outcomes.** Nossel, I., Wall, M.M., Scodes, J., Marino, L.A., Zilkha, S., Bello, I., Malinovsky, I., Lee, R., Radigan, M., Smith, T.E., Sederer, L., Gu, G., Dixon, L.

into the progress note). Similarly, substance use disorder data is highly sensitive and is often put into the progress note, which makes accurate meta-data tagging and interoperability of high importance.

Finally, patients often have records stored within multiple EHR systems as an artifact of seeing multiple care providers, due to comorbid/concurrent medical diagnoses (e.g., substance use disorders in residential or outpatient clinics; solo practitioner psychiatrists; primary care providers; emergency department records; inpatient psychiatric facilities). This highlights the urgent need for better interoperability between systems, with better capability of tracking disclosures as the record is transferred between them through health information exchanges (HIEs).

***APA has several concerns when contemplating addressing these barriers and burdens around HIPAA and HITECH for coordinated care and case management:***

- Most standalone EHR systems (i.e., those not complemented by additional software) do not appear to be capable of tracking each incidence of use or disclosure of the patient's record. This is due to several reasons: 1) a lack of 100% interoperability between EHR systems results in these systems either sharing information differently or not sharing at all, when, how, and by whom a patient's record is accessed; 2) some EHR systems may not track access and disclosures in useable/readable way by patients. In both cases, the patient would be left with an incomplete picture of who accessed their records, and when.
- Patient records often touch many different types of providers in different ways: via fax, e-mail, hand delivered on an inpatient unit, and so on. Relatedly, the claims associated with each of these providers for payment purposes also touch many other third parties, such as independent billing agencies, between different types of billing software systems (separate from the EHRs), and insurance companies. This further complicates matters when the patient attempts to access a complete list of uses and disclosures.
- The disparate ways in which patients can request records (e.g., through a patient portal; in-person at a hospital's records department, etc.) and whether the "output" of these requests in useable/readable by patients, creates an additional barrier for the patient in accessing an accounting of their record disclosures.

The above issues highlight the difficulty in addressing the individual questions posed by the ONC in this RFI. EHR systems can be capable or incapable of tracking uses and disclosures; they may track uses and disclosures in different ways; hospitals and providers may or may not track the frequency with which patients request such information; this information, when requested, may or may not provide a complete picture of uses and disclosures of the patient's record. Finally, it is highly variable whether the patient would even be capable of interpreting these data.

***The APA is confident that the ONC will continue to address these interoperability and standards-related issues after receiving public feedback on their "Draft Safety on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs," future iterations of its "Health IT Certification Program," and in the forthcoming, "EHR Reporting Program," another 21<sup>st</sup> Century Cures Act mandate.***

***Each of these initiatives has the potential to bring numerous stakeholders to the table, including clinicians, policymakers, and standards organizations (e.g., HL7).*** This type of dialogue will enable the ONC to develop a feedback loop between these stakeholders and future regulations around HIPAA and HITECH, which will hopefully address the issues outlined above.

### **Confidentiality of Substance Use Disorder Records**

Lastly, the implementation of Title 42 of the Code of Federal Regulations (CFR) Part 2 (“Part 2”) which regulates the confidentiality of certain substance use disorder records continues to be a barrier to meeting the whole health needs of patients with mental health and substance use disorders (MH/SUDs). Without access to a complete record, providers cannot properly treat the whole person and may, unknowingly, endanger a person’s recovery or life. For example, a doctor may not know that he or she is prescribing pain medication to someone with a history of addiction or prescribing a medication that has drug interactions with methadone (with serious potential side effects of the drug interaction such as arrhythmias). Recent revisions made to the regulations do little to ease the administrative burden and uncertainty that providers encounter when trying to comply with Part 2, making it more difficult for individuals with SUDs to benefit from high-quality, coordinated-care models, which are the future of health care delivery.

We strongly support provisions that prohibit Part 2 information from being disclosed for non-treatment purposes to law enforcement, divorce attorneys, or others who seek to use the information against the patient. However, the regulation has proven to be such a challenge to implement that SUD treatment is often an afterthought or is separated from efforts to improve health services. ***Overall, we recommend alignment of the Part 2 requirements with HIPAA for the purposes of treatment, payment, and operations. We strongly urge HHS to revise the Part 2 regulations to allow for better alignment between the privacy regulations.***

Thank you again for your work on this important issue. If you have any questions, please contact Michelle Dirst, APA’s Director of Practice Management and Delivery Systems Policy at [mdirst@psych.org](mailto:mdirst@psych.org).

Sincerely,



Saul Levin, MD, MPA, FRCP-E  
CEO and Medical Director