Netsmart Comments
Partnership to Amend 42 CFR Part 2 Congressional Briefing
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Good morning…I'm pleased to be here representing Netsmart and our more than 25,000 clients with 500,000 clinicians in all 50 states. With headquarters in Overland Park, Kansas, we're the largest technology solutions provider serving behavioral health and post-acute care. Our clients include residential and outpatient substance use treatment facilities and more than 300 methadone treatment clinics. Our 1,400 associates help providers improve the lives of more than 25 million people every day.

Healthcare is in the midst of rapid change and evolution. The topic of information sharing brings to mind providers from behavioral health, substance use treatment, public health, child and family services, home health, hospice and long-term care. It's critical that these previously siloed areas of care connect with each other to provide fully-informed diagnoses and treatment. Many of the persons they serve have multiple co-occurring health conditions, and can benefit from coordinated care…and the cost of care can be reduced.

To achieve whole-person care, anyone – whether suffering from mental illness, diabetes, a substance use disorder, or multiple co-occurring conditions – should be able to share all or portions of his or her health data with their healthcare providers with equal simplicity, using today's technology, regardless of their diagnosis, if they so desire. If someone does not wish to do so, they should have the clear option to either opt-out or not to opt-in to sharing that information.

Today I want to mention two technology hurdles that significantly hinder the ability of persons with a history of substance use treatment from receiving "whole person" care...and providers from giving it. These issues would be alleviated by the passage of the legislation being discussed today.

Under current 42 CFR Part 2 regulations, providers, including those in integrated care settings – like Health Information Exchanges (HIEs), Accountable Care Organizations (ACOs) or Integrated Health Homes – are required to "segment," or separate out, substance use treatment information from the health record to prevent its disclosure to other treating providers not in the same integrated care setting. And, they need to allow for the remainder of the health record to be shared. This is commonly called data segmentation, and it provides an incomplete picture of a person's health to their treating providers. One example of a resulting risk is a clinician prescribing an opioid medication to someone who has an opioid addiction because it was not included in the health record he or she received.

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Data segmentation is complex to implement. While some EHR providers, including Netsmart, can segment data, most other EHR and HIE providers will need to modify their systems to do so. For this to happen, the federal government will need to designate standards and mandate this capability in some form of regulation for all EHR, HIE, population health and care coordination vendors. The cost of modifying all these systems would be significant. Best case, Netsmart believes that a robust system capable of supporting this type of segmented data would not be available for 7-10 more years. In the meantime, most providers and HIEs do not have the resources to modify their systems to support it. This inconsistency and confusion has resulted in some statewide HIEs not accepting substance use treatment patients at all.

A second issue is lack of consistent and effective consent processes. Consent2Share is a web-based application developed by SAMHSA, intended to make it possible for a person to choose which parts of their information can be shared with other providers. While a laudable goal, there are significant resource, cost and technology challenges to implementing Consent2Share. Every healthcare provider...every hospital, physician practice, specialty medical practice, ACO, Medicaid Health Home and others would need to modify their existing EHR systems in order to accept Consent2Share. They would also all have to train their staff on special consent requirements related to addiction medical records with Consent2Share…and train patients with Access 1 opioid addiction disorders on how to use it.

In its January 2017 Final Rule, SAMHSA estimates a $250 million cost to implement Consent2Share. Based on the size of our own Netsmart client base and that of other technology providers, we think the cost would likely be 3-4 times higher…exceeding $1 billion.

A SAMHSA official speaking in a breakout session at last week’s ONC Annual Meeting here in Washington acknowledged that there has been:

- “Very low” nationwide implementation levels for Consent2Share
- And that only one health information exchange and no hospitals in the U.S. have implemented it

If a goal of the updated rule was to enable the sharing of electronic addiction medical records more broadly in integrated health settings, it’s clear that to this point, the technology developed to attain that objective has not met expectations.

Thanks to Congressman Mullin, Congressman Blumenauer, Senator Capito, and Senator Manchin for sponsoring today’s briefing…and key legislation that would help alleviate these issues and others discussed here this morning. We appreciate the opportunity to participate, and look forward to providing more input in the future.