



January 28, 2019

The Honorable Donald W. Rucker, MD

National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C St SW
Floor 7
Washington, DC 20201

Comments submitted electronically only

Re: Draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs.

Dear Dr. Rucker:

We at **Centerstone** applaud ONC's efforts in aiming to reduce regulatory and administrative burdens on the healthcare industry, and are grateful for the opportunity to provide comments. As a front-lines provider of evidence-based behavioral health services, our priority is to provide the highest quality, integrated care to our patients. This goal is sometimes complicated, however, by regulatory requirements. Our below comments focus on the threats to coordinated, quality care posed by the Federal Confidentiality of Substance Use Disorder Patient Records regulation (42 CFR Part 2) referenced in your draft *Strategy*.

[About Centerstone](#)

Centerstone is one of the nation's leading not-for-profit providers of mental health and substance abuse disorder services, dedicated to delivering care that changes people's lives. Centerstone is a multi-state organization bringing evidence-based treatments and care to nearly 180,000 individuals with an array of behavioral health disorder and challenges residing throughout Florida, Illinois, Indiana, Kentucky, and Tennessee. In operation for over 63 years as a front-lines provider of both inpatient and outpatient services, we can easily identify the most significant barriers to systematically providing unencumbered behavioral health care to children and adults, alike, in both urban and rural areas. Centerstone is the only not-for-profit, behavioral health care provider with a research institute embedded within the organization, directly connecting the latest knowledge into clinical care. Our Research Institute develops clinical innovations based upon the very best science that promises to produce better outcomes, increase value, and help close the 17-year science-to-service gap. Finally, our Military Services bring specialized care to veterans, regardless of service era or discharge status, service members, and their families across the entire swath of the United States.



42 CFR Part 2 Hinders Integrated Behavioral Healthcare

We at Centerstone aim to do everything we can to evaluate what is most appropriate for each individual on a case-by-case basis in order to provide the highest quality, individually-tailored care. Without a full understanding of the challenges an individual is facing, however, the care of even the best-intentioned providers will fall short of the care they could offer if they understood the whole person. Part 2 is an immense barrier for all health care providers in treating substance use disorders with the same degree of coordination, collaboration, accountability, and attention as all other health conditions. Unfortunately, it also reinforces the stigma of addiction by segregating substance use disorder treatment from the dominant health care system. **Therefore, we strongly recommend that Part 2 be aligned with HIPAA to allow for the transmission of vital patient SUD records without additional consent for the limited, but significant purposes of treatment, payment, and health care operations (TPO).**

Absent a medical emergency, Part 2 currently prevents medical personnel from seeing a patient's substance use disorder history.¹ As such, Part 2 restricts the essential coordination of care component of health care collaboration. This can lead to unintentionally dangerous health care outcomes for those experiencing a substance use disorder. With limited access to vital medical records, practices commonly used across healthcare, such as screening, assessment and referral to treatment are ignored. In contrast, HIPAA allows for providers to communicate appropriately outside of just emergent situations, opening the doors for a full continuum of timely care.

Centerstone Vice President of Adult and Family Services, Linda Grove-Paul, has observed that: *“Part 2 provisions are not compatible with the way healthcare is delivered today. This provision, put into place in the early 1970s, was created decades before HIPAA or electronic health records existed. Access to a patient's entire medical record, including addiction records, ensures that providers have all the information necessary for safe, effective, high-quality care.”*

Furthermore, Dr. Richard Shelton, Chief Executive Officer and Chief Medical Officer for Centerstone Research Institute has explained that: *“Today, if a behavioral health provider is referred a patient by a primary care doctor, he or she is unable to share with that primary care physician that the patient has been diagnosed with or is being treated for an addiction. This lack of transparency can lead to situations in which providers may accidentally pose safety threats to their patients with substance use disorders by unknowingly recommending incorrect or harmful treatment. By treating substance use disorder like all other medical conditions and ensuring that providers have all the information necessary to deliver safe, coordinated, effective, high-quality care, we can improve our health care system's ability to treat addiction and allow providers of all kinds to help get more people on the path of recovery.”*

¹ 42 CFR § 2.51(a)



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Part 2 Problems in Practice

Recurring Situation:

Centerstone builds and maintains relationships with Primary Care physicians (PCPs), as they are a key component in providing the best care. When a PCP determines that his/her patient requires specialty care to address a potential mental illness, the PCP refers that patient to Centerstone. Usually, after Centerstone has assessed the patient, we send the referring PCP treatment progress reports to keep them apprised of how their patient is doing in our care. However, if a patient has a substance use disorder (SUD), we cannot disclose any treatment progress information, any information relating to a patient's substance use, substance use history, treatment for substance use, medication to assist with substance use treatment, or anything that would tangentially indicate the presence of a SUD in a patient, unless that patient signs a separate release in advance. We are unable to even alert the PCP that we have made a substance use diagnosis on a patient without a patient's prior written consent. Without a separate consent, PCPs are left completely in the dark. Furthermore, when a patient does not sign a second release form, we not only lose the opportunity to coordinate a patient's care (to their benefit), but we also run the risk of causing further complications for the patient as a result of unknowingly prescribing contraindicated medications to our patients.

In the case of pregnant women with SUDs, the risk is even higher: not only is the mother at risk of going untreated or improperly treated, but so is the unborn child. Mothers who continue to use during pregnancy and who do not wish to sign secondary releases to allow her care providers to treat her comprehensively, inevitably put their unborn children on a path of almost certain opioid addiction. As a not-for-profit provider subject to Part 2, Centerstone providers have to sit passively on the sidelines as these scenarios play out in front of their eyes, while private providers have the free reign to offer care in line with less-stringent, common-sense, HIPAA guidelines.

Specific Example:

A young man was referred to Centerstone from a surgeon who had concerns about depression in his patient. The referred individual had complex medical needs due to an injury. Upon initial referral, it appeared as though the young man had some mental health concerns that were being treated with an anti-depressant and a benzodiazepine, as prescribed by the surgeon. When assessing the young man at our community mental health center for mental health and addiction services, we developed serious concerns about the possibility of overlapping addictive disorders including opiate, benzodiazepine, and alcohol addiction, in addition to a depressive disorder. Due to the severity and combination of drugs the man was using, there were major safety concerns. Furthermore, the young man's support system was shallow - he was not from the area and had no friends or family that lived locally. He had concerns about signing releases of information for any of his family that lived out of town or for any other health care provider because he feared he would no longer be able to hide his addiction from them, or obtain medication from other providers to support his addiction. Due to the complexity of his medical condition, he was able to easily obtain both opiates and benzodiazepines from separate medical providers. Being honest about his addiction would have resulted in him no longer having access to the drugs that were being legally prescribed to him – ones that were threatening his wellbeing and posing high levels of lethal risk of overdose.



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After consulting with psychiatric staff, we determined he was in need of an additional psychiatric assessment before potentially starting him on Suboxone to aid in staving off his addiction to opiates. The fear remained, though, that he would continue to access benzodiazepines, which, if combined with Suboxone, could be dangerous. As part of the terms of his Suboxone treatment, he had to agree to sign releases of information to his other medical providers so that his psychiatrist could inform them of his full condition, which, if ignored, could be more lethal than any of the other complex conditions he was being treated for. After several months, the young man agreed to be more open about his opioid use, and agreed to involve more and more individuals in his care by signing additional releases of information. Shortly after he signed a release for his mother, he had a significant relapse. Thanks to the ability to correspond with his mother and other treatment providers, the treatment team intervened to get him immediate medical attention and follow-up inpatient treatment that led to a longer term residential placement. If the young man had not signed the ROIs for his mother or his other health care providers, his providers would have been extremely limited in how to proactively respond to his needs. **Without an ability to share the young man's full medical history, he would have been at high risk of death.**

Conclusion

Addiction records are now the only records not wholly governed by HIPAA's Privacy Rule. In its current form, Part 2 denies individuals with substance use disorders the benefits of preventative, integrated care readily available to those experiencing any other chronic condition. Alignment of Part 2 with HIPAA for the purposes of TPO would enable all health care providers, not just behavioral health specialists, to have the increased ability to engage in potentially lifesaving collaborations across health care systems, which would markedly improve substance use disorder treatment standards.

ONC has the opportunity to make a meaningful difference in the way our providers treat patients with SUD. We recommend alignment of Part 2 with HIPAA for the purposes of TPO to bring SUD treatment into alignment with the standard of care for all other chronic conditions. Thank you, in advance, for your consideration of our input. Please do not hesitate to reach out to us should you wish to discuss further.

Sincerely,

Lauren McGrath Conaboy, MSSW
Vice President, National Policy, Centerstone

Monica Nemec, JD, MPP
Director, National Policy