



# Testimony

## MA Health IT Listening Tour

Good morning. My name is George Kimes. I am the Executive Director of the Pennsylvania Community Providers Association (PCPA). Founded in 1972, PCPA represents over 200 community-based mental health, intellectual disabilities, substance abuse, and children's agencies across the commonwealth. Our member agencies cover all 67 counties, providing services for over 750,000 Pennsylvanians each year. PCPA provides advocacy for improving the human service system, information on legislative and regulatory issues, and education to the professional community. Our members are an important part of the safety net and are the leading providers of behavioral health services in the Pennsylvania Medicaid program.

I appreciate the opportunity to represent the views of the members of this association. I want to thank the Department of Public Welfare for holding these listening sessions and providing our segment of the industry an opportunity to comment on this critical issue. I also want to thank the Office of Medical Assistance Programs (OMAP) for inclusion of PCPA as a representative of the behavioral health community on the Medical Assistance Advisory Committee – Health Information Technology (HIT) Work Group.

I would like to begin my testimony by describing my view of the problem regarding community behavioral health providers and the adoption of Health Information Technology. It is my experience that behavioral health providers lag far behind the physical health care community in adoption of health care information technology. There are many reasons for this gap, but in my opinion, lack of financing is the primary cause. The 2009 *Behavioral Health/Human Services Information Systems Survey* was conducted under the direction of the Mental Health Corporations of America, the National Association of Psychiatric Health Systems, the National Council for Community Behavioral Healthcare, and the Software and Technology Vendors Association. Results from the national survey highlight the lack of resources for behavioral health organizations to quickly expand information systems.

The survey identified many key findings that impact information technology (IT) capabilities of behavioral health providers. The survey showed that mental health/addictions service providers spend only half as much as primary care providers on HIT. Similarly, these community organizations employ only about a third as many IT professionals. Another very revealing result is that less than half of all behavioral health and human services providers have fully implemented electronic medical record systems. The survey also indicated that the future for IT expenditures is no brighter. Most of the providers responding expect to spend even less on HIT next year due to budget cuts, reduced reimbursements, and greater demand. Please remember, this was a national survey. Based on my knowledge of PCPA members adoption of technological improvements, Pennsylvania community providers are even further behind than the national norm in the adoption of the latest technology. Although I can point to some providers who have successfully implemented comprehensive electronic medical record systems and are fully utilizing them, they are the exception.

On the positive side, the national survey clearly indicted that, if resources were made available, overall HIT spending would increase in community behavioral health. Likewise, I know that the providers I represent are committed to adopting HIT improvements if additional support is available. PCPA members primarily serve public sector clients through both the Medicaid and county-funded programs. Years of very limited program and rate increases have included no funding for technology improvements.

The passage of the *American Recovery and Reinvestment Act* (ARRA) in February 2009 led to some hope that behavioral healthcare organizations might finally get some assistance in technology acquisition costs. While Section 3000 of the act did include "community mental health centers" as eligible organizations, many of us were disappointed to see that community behavioral healthcare organizations were not included as "eligible providers" in the Medicare and Medicaid incentive sections. Our national organizations are working to remedy this, but I want to thank OMAP for recognizing that the behavioral health provider organizations employ and utilize physicians and certified registered nurse practitioners (CRNPs) that are eligible providers for those incentives. There may well be some organizations able to access some of the incentive funds through the eligible providers in their organization. Eligibility for the organizations would be a better solution, but we do appreciate the efforts to make sure that the thousands of Medicaid consumers served in the community provider system might receive some benefit from ARRA funds. Again, thank you for this recognition.

Bringing the behavioral health community up to speed on the technology side is critical and will be even more important in the future. The behavioral health system is behind in the adoption of e-prescribing. Other trends, such as the increasing use of evidence-based practices requiring state-of-the-art technology, also lag behind physical health care. Recovery-oriented care models as promoted by the department require better control and management of care for persons receiving services, including the individual's medical record. All of these trends require improved technology and must be supported by the department.

One of the most important issues we face is the integration of physical and behavioral health care. People in the US with serious mental illnesses such as schizophrenia and bipolar disorder die an average of 25 years earlier than other Americans, according to a 2007 study conducted by the National Association of State Mental Health Program Directors. Three out of every five people with serious mental illnesses die from preventable, co-occurring chronic diseases such as asthma, diabetes, cancer, heart disease, and cardiopulmonary conditions. Fighting this deplorable condition requires improved coordination between the physical and behavioral health care system. In a recent speech, Secretary of Health and Human Services Kathleen Sebelius supported integrated care programs. Secretary Sebelius said:

We know that these integrated care models can be especially effective when they combine behavioral and physical health conditions. That's because mental illnesses and substance use disorders usually go hand in hand with other physical conditions. We know that the sicker you are, the more likely you are to be depressed: forty percent of older patients with advanced heart failure have major depression. And we also know that when physical and mental health problems come together, they usually make each other worse. For example, the cost of treating a patient a medical problem and comorbid psychiatric condition is twice as high as the cost for a patient with the medical condition alone.

There are many developing models of integrated care, including “medical homes” for people with serious and persistent mental illness. It is, however, the adoption of technology improvements such as the electronic medical record and the electronic health record that holds the best promise for successfully improving this integration of care. If Medicaid-eligible Pennsylvanian’s are to be given the opportunity to experience these improvements, the public behavioral health system must be supported with adequate funds for technology improvements. We appreciate the recognition of these needs for providers in the public system and will continue to look for your support to keep the behavioral health community moving forward.