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Paper charts are truly on

the way out of healthcare. The ability to cost effectively assure quality data and care delivery documentation by handwritten documentation is not practical. Federal initiatives beginning with President Bush's Executive Order No 13335 setting incentives for information technology and the creation of a National Health Information Technology Coordinator (formerly Dr. David Brailer, M.D, Ph.D.) and the release of the Decade of Health Information Technology-Framework for Strategic Action have set in action numerous committees and workgroups targeting the development of a National Health Information Network. The vision of most of these initiatives is to pass patient data from care provider to care provider in order to improve patient safety and reduce cost of health care delivery in the United States.



The ability to exchange data between different software systems is technically feasible and in some TIER® installations is currently happening. These installations utilize HL7 (please visit <http://www.hl7.org/>) interfaces where TIER® sends and receives information from other provider software systems. Traditionally data exchanged are admission, discharge and transfer (ADT) data or laboratory or pharmacy order data. Such exchange is only due to a mutually agreed to data standard (HL7) and its accompanying rules for exchange. HL7 is a widely used and established protocol for data exchange within hospital settings and it is extremely effective and efficient. HL7 will become increasingly important to all TIER® users in the near future. It will be the committee that builds the data dictionary of the universal electronic chart. The question will be "Who tells these data standards architects what a behavioral/chemical dependency chart/ include?"

Behavioral health and chemical dependency providers have been slow to adopt such standards for exchanging data-largely due to lack of technology within their facilities, extreme differences in practice and an ownership of their clinical processes/content. How and where do we begin to overcome these obstacles in the next 9 years-currently one year into the year of health information decade? While there are tremendous policy and political arguments against the exchange of this data outside your own organization-there also exists no standard that is recognized as a universal BH/CD chart. By now you are saying this will never happen in our market-just impossible! I would encourage you to visit some government sites that discuss this

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process - <http://www.hhs.gov/healthit> , <http://www.cchit.org> , <http://www.samhsa.gov> ,
<http://www.himss.org> , <http://www.medrecinst.com> , www.satva.org .

The past two years have witnessed the rapid definition and establishment of an ambulatory care data standard – **Certification Commission for Healthcare Information Technology**. The thought of having a medical check up documented in Hospital A software system and sent to Hospital B, incorporated into their software for review prior to an emergency room visit and then the entire history sent to Hospital C for a scheduled appendectomy and ingested to that software is difficult to grasp. Aside from the complexities of these records, visits and procedures-each software system is owned and operated by different companies-competitors. Well in fact this process was demonstrated by several software systems during an HIMSS conference in San Diego, California. So much for complexity and proprietary boundaries!

In my previous role as Chairman of the Software and Technology Vendors Association's (SATVA) Board of Directors, I have become increasingly surprised at the speed with which the federal government is supporting the initiative of a National Health Information Network. There are several forces working diligently to assist the development of standards that will truly reflect the many data elements collected throughout all our various paper charts. Projects such as Decision Support 2000 and MHSIP began focusing on standards and are joined by the Behavioral Health Data Standards Workgroup. Many mental health associations such as National Council of Community Mental Health (NCCBH), Mental Health Corporations of America (MHCA) and SATVA have petitioned successfully to be at the appropriate tables that will eventually submit the data standards for an interoperable electronic chart. My past work as a social worker did not include macro political advocacy-just not my thing! However my message is that I do think many of the changes related to interoperability and a National Health Information Network will happen to behavioral health and chemical dependency treatment-despite any objections. I am concerned that too few of our groups are actively engaged in the appropriate dialogues that will ensure our voice is heard. The government will pass laws regardless of many of your abilities to meet them-I still visit places today that are not capable of maintaining systems according to HIPAA standards. I encourage you to speak to policy committees, trade associations and each other related to what current legislation includes and where it is headed for our profession.

My clinical education and background lead me to ponder the challenges and practical impact of a National Health Information Network (NHIN) that will hold everyone's health records-medical, behavioral and substance abuse histories. At one time-two years ago-I thought the technology would be difficult-now I have discussed and designed how to send a mental health record from TIER® Workflow System to one of our competitor software products and vice versa. I am certain the movement of patient data between systems will improve care delivery; however I am acutely aware of the many political and clinical challenges that lie ahead of us to achieve interoperability.

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