

**Medical Society of the District of Columbia**  
**Testimony Before**  
**The Committee on Health and Human Services**  
**On The**  
**Behavioral Health Coordination of Care Amendment**  
**Act of 2015**  
**Bill 21- 0007**

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**Chair of the Board**

**Carla Cargill Sandy, M.D.**  
**President-elect**

**February 4, 2015**  
**11:00 A.M.**

**The Behavioral Health Coordination of Care Amendment Act of 2015**  
**B21-0007**

Chair Alexander, members of the Committee, good morning. My name is Dr. Catherine S. May and I am testifying today as Chair of the Board of Directors of the Medical Society of the District of Columbia (MSDC) and on behalf of our 2,800 members. I have lived in the District of Columbia and have practiced medicine in the District for 30 years. I am Past-president of the Washington Psychiatric Society, have been a five term ANC Commissioner and, for 20 years, was the Medical Consultant to the Woodley House Programs which delivers care and housing to underserved District residents living with mental illness. I am trained in both Emergency Medicine and Psychiatry and as such I have experienced both the frustration of not having access to necessary information and the acute awareness of the need to maintain the confidentiality of sensitive, private information and patient confidence in psychiatric care. With me is Carla S. Sandy, M.D., President-elect of the Medical Society and Chief of OB/GYN with Kaiser Permanente's Mid Atlantic medical group, involved in both direct patient care as well as administrative and clinical oversight for Kaiser's two health centers in the District of Columbia. On behalf of the entire medical community and the thousands of patients whom District physicians treat each day, I thank you for holding today's hearing on the Behavioral Health Coordination of Care Amendment Act of 2015 and for considering the remarks that follow.

The Medical Society supports the Behavioral Health Coordination of Care Amendment Act of 2015 and commends you and Councilmember Grosso

for its introduction. At the same time, you will hear today that the legislation requires some additional work to ensure that the goals we are all trying to achieve - enhancements in patient care and better integration of mental health care into primary and specialty care - is achieved.

The caution that I would express at this point is that we not go from a law which in its implementation has resulted in obstacles to optimal patient care to a law that, as written, is overly broad and jeopardizes the privacy of mental health records to the detriment of patient care. The Medical Society believes that the use of “health professionals” in line 28 is overly broad, especially as “health professionals” is defined in DC Code 3-1201.01. At the same time, restricting facilities to only “mental health facilities”, also in line 28, is overly restrictive. These concerns are easily addressed and we will work with your staff in crafting amendments that correct what, we believe, are unintended consequences.

By way of background, the Council of the District of Columbia passed landmark mental health legislation in 1978. The benefits and protections that the law has provided over the past 36 years to patients cannot be disputed. At the same time, the passage of time and certain events have changed the practice of medicine. There is a need for more timely access to necessary information and a greater appreciation for the need to better integrate necessary mental health information into the overall medical record used by the patient’s team of caregivers to facilitate the timely delivery of care. What has not changed is the need to protect the confidentiality of sensitive and private mental health information and the MSDC believes that Bill 21-0007 can achieve both these goals.

The most significant event to have occurred in ensuring that a patient's medical record remains confidential and is protected from unnecessary or unauthorized disclosures was the passage in 1996 by Congress of the Health Insurance Portability and Accountability Act (HIPAA). In HIPAA, Congress incorporated provisions that mandated the adoption of minimum federal privacy protections for individual identifiable health information. Following the passage of HIPAA, two additional laws, the HITECH Act and the Patient Protection and Affordable Care Act of 2010, further strengthened the privacy protections afforded to patients. None of these laws and their protections was on the books 36 years ago, and so it is appropriate that we revisit the privacy protections contained in the original Mental Health Information Act of 1978.

To be clear, the federal laws which we have referenced establish a floor or baseline of privacy protections, not a ceiling, and so the District law, which has set a higher standard, has not been preempted by the federal statutes. The problem that is clear is that the obstacles to appropriately sharing necessary mental health information with other members of the treatment team are not in the patient's best interest. MSDC believes that mental health information should be made available in a timely fashion to members of the health care team and facilities caring for a patient when and to the extent necessary to deliver good medical care.

This legislation as currently written is a good first step, but can be made better. We think that there is benefit to having additional time between today's hearing and mark-up to ensure that we get it right. I am proud of the

collaborative process that the Medical Society has been a part of the past two months, working to develop a consensus among the stakeholders and caregivers as we work to balance the need for privacy with the need for the necessary medical and mental health information to appropriately treat our patients. It's been a diverse group but one with a common goal of improving outcomes for patients.

At this point, I do want to clarify one point that came up when the Council held hearings on similar legislation several years ago. Psychotherapy notes are not part of our discussion here today. Those notes enjoy even more privacy protections under HIPAA and would continue to do so in the District even with the passage of this legislation. The privacy rule will continue to require the patient's signed release and authorization for any release of psychotherapy notes. The Bill as introduced also preserves the charge that mental health information be exchanged when and to the extent necessary to facilitate care. This proviso both offers clinicians discretion in determining which information to release and can offer reassurance to those who may be concerned that their sensitive mental health information would no longer enjoy protection. Nothing in this legislation will change that nor should it. Dr. Sandy and I look forward to your questions and look forward to working with you, your staff, and the other stakeholders in making sure we make a good piece of legislation even better prior to its consideration by the full Council. Thank you.