The following statement was submitted online to Battelle on December 13, 2025 by:
NHMH – No Health without Mental Health
American Association on Health & Disability
Clinical Social Work Association
Lakeshore Foundation
The Policy Center for Maternal Mental Health

RESPONSE to BATTELLE REQUEST for COMMENT on
DIGITAL INTEGRATED MEDICAL-BEHAVIORAL EHRs and DIGITAL QUALITY MEASURES

Key Points:

***Integrated EHRs and dQM lead to better quality of holistic care, care coordination, outcomes**
*** Behavioral health data standards made stronger since lag medical**
*** Interoperability standards should include BH data standards as key to data exchange**
*** Patients' privacy, control over data-sharing, and consent, built into data systems**
*** Involve patients and advocates early in dQM design phase.**

INTRODUCTION:

Integrated EHRs and dQMs are Foundational: Integrated medical-behavioral EHRs and dQMs are foundational components of a much-needed healthcare delivery transformation. One that is technology-enabled, data-driven, and prevention-oriented. One able to provide patients with whole person health care, reduce provider burden and health system fragmentation, and support CMS's goals to better manage Americans' chronic care conditions.

Accurate, timely integrated behavioral and physical health data should enable interoperability, better measurement of value, improved outcome tracking, a stronger evidence base for delivery and payment models, and create a technology-enabled health system. It can provide for new data flows from integrated EHRs, applying the FHIR data standard for medical data integration and interoperability, to practice quality dashboards, to CMS and other payors quality measure reporting.

Yet Basic Problems Remain: CMS has developed value-based payment arrangements using a set of quality measures progressing along parallel pathways: structural measures, process measures, and outcome measures. The problem is that few valid and feasible process and outcomes measures exist to support integrated care and there are gaps in how the efficiency of integrated care is conceptualized and measured. Further, outcomes measures that do exist focus on single-disease or populations, rather than the reality of multimorbidity in this patient population, with the exception of the TEAMcare model developed by Wayne Katon, MD of UW/AIMs in 2010 and not widely implemented or disseminated since.

Key bottlenecks to implementation of integrated care remain: the need for scaled primary care clinician payment reform; development of quality metrics for value-based payment; and solving the demands on the primary care system meeting the complex needs of patients with chronic conditions. Contextually, primary care clinicians face a trifecta of challenges: lack of time, minimal training in mental health/addiction, and a lack of care coordination between healthcare providers and community social services. In this environment, integrated EHRs and digital quality measures can potentially play a vital role advancing integration implementation and should be a priority by CMS with input from patients and advocates.

Our recommendations:

1) CMS make patient health data easier to access and share consistent with privacy and confidentiality legal requirements; this should include clear rules on information-blocking where practices interfere with the access, exchange, or use of electronic health information by patients, healthcare providers, or health IT developers. It is considered illegal under the 21st Century Cures Act, which mandates that patients should have easy access to their health information.

2) CMS should ensure parity between behavioral health and medical providers in HIT technology capacity, participation, technical know-how, and financial sustainability.

3) CMS ensure patients and advocates have an essential role in the design and operation of digital quality measurement development, operationalizing, testing, adoption, aligning across multiple payors and programs, and updating measures over time.

Below are our replies to the specific questions raised by Battelle:

Q1.What opportunities and challenges are associated with developing/testing dQMs?

CHALLENGES Associated with Developing/Testing Digital Quality Measures:

-- Different EHRs: medical and behavioral providers often use different EHRs with incompatible data structures thus making digital quality measurement for behavioral health and behavioral health integration a challenge.

-- Digital Data Standards Stronger for Medical Data -,existing digital data standards for the exchange of health data, like the widely accepted FHIR (Fast Health Interoperability Resources) and HL7 standards, have stronger coverage for medical data than for BH data.

-- Evolving Data Standards: Also existing FHIR and HL7-based measure reporting standards are still evolving, which adds complications during development/testing.

-- Unstructured BH data: BH information (e.g. validated scales, therapy notes, mood scales) are often in unstructured text making it difficult to map to standardized vocabularies such as LOINC, SNOMED or IC-10.

-- Privacy Requirements: MH and SUD data have stricter sharing restrictions than general medical data, and consent elements for what data can be shared and with whom, are often not built into EHR systems.

-- BH Data Variability: inconsistent documentation, different assessment tools and non-standard

coding make quality measurement difficult; BH encounters often under-documented especially those outside traditional healthcare settings (telehealth, peer support, community programs); large portion of BH information is in free text or narrative notes (i.e. unstructured).
-- Small Practice Constraints: BH providers are often small organizations lacking IT infrastructure and funding for EHR integration.
-- Alignment: Different quality measure specifications such as NCQA, CMS, State-level programs, generate confusion hindering implementation.
-- Measurement-Based Care Processes Lacking – most independent behavioral health providers do not apply measurement-based care processes, and a large proportion to not accept insurance, primarily due to low reimbursement rates as compared to medical rates.

OPPORTUNITIES Associated with Developing/Testing Digital Quality Measures:

-- Data Exchange: adoption of accepted data standards such as FHIR and HL7 enables data exchange between medical and behavioral health providers/systems for digital quality measurement.
-- Advance Behavioral Standards: expand behavioral data standards within FHIR and USCDI.
-- USCDI Expansion to BH: ongoing expansion of the U.S. Core Data for Interoperability (USCDI) to include behavioral health better supports integration of medical and behavioral EHRs from which quality measures can be reported.
-- Payment Alignment: value-based models increasingly require integrated medical-behavioral data for quality reporting and reimbursement.
-- Development of Accreditation Standards – opportunity for development of accreditation standards for measurement-informed care at payor and provider levels accompanied by evidence-based clinical guidelines.
-- Prevention, Early Identification: combining behavioral and medical data allows for early identification of risks such as hospital readmission, ED visits or suicide risk.
-- Patient-Centeredness: digital consent tools and identity management tools give patients ability to control data sharing actively; incorporation of data from wearables, MH apps and SDOH surveys deepens dQM datasets.
-- Cross-Sector Collaboration: integrated medical-behavioral EHRs for digital quality measurement encourages collaboration among healthcare providers/systems, public health, and social service providers.
-- Small Behavioral Health Provider Support: providing funding and technical assistance for small provider behavioral health integrated EHR adoption.

Q2.*How will dQMs impact positively or negatively impact the healthcare community (patients, providers, payers, and others)?*

IMPACTS – Positive and Negative on Key Stakeholders:

Patients/Families – Positives:
-- receipt of better quality of care as clinicians see both physical and behavioral conditions in one shared record improving care coordination and outcomes.
-- improved whole person care in terms of early identification and prevention since integrated

medical-behavioral data can flag BH needs earlier such as depression screening after heart attack or substance use risk in chronic care patients.
--patients no longer have to be continually repeating their behavioral history across diverse clinicians in disconnected systems.
-- patient control over their data - patients can see integrated records and quality performance.
-- shared decision-making - research shows that when medical and behavioral care is integrated, and tracked systematically, there are improvements in chronic disease management, medication adherence, and patient satisfaction.
-- better information for selecting providers that are appropriate to individual patient needs.

Providers and Health Systems – Positives:
-- real-time quality feedback, clinicians can see up-to-date dashboards showing patients' status across both medical and behavioral domains.
-- better enable providers to identify the need to adjust/intensify clinical strategies from a menu of evidence-based options.
-- reduced reporting burden – automated dQMs eliminate manual chart review and reporting allowing more time for direct patient care over paperwork;
-- clinical decision support – integrated data triggers alerts and reminders prompting primary care providers to follow up on behavioral scale scores when prescribing.
-- better team-based care – medical, behavioral and care management personnel can track shared metrics reinforcing collaborative care.
-- permits financial sustainability – reliable measurement allows provider practices to show impact of BH integration to payers and funders, supporting sustainability.

Payors – Positives:
-- integrated data allows payors/insurers to measure outcomes that reflect both physical and behavioral dimensions, enabling alignment of incentives with whole person care.
-- contracts that reward performance – plans can reward providers for achieving integrated measures such as depression remission or improvement in diabetics, or reduced ED use among patients with behavioral comorbidities.
-- payors can more accurately identify patients with multiple chronic comorbidities.
-- integrated data can guide payment and network adequacy decisions for behavioral health services addressing their persistent underpayment and network inadequacy.
-- more effective integrated care strategies, especially those incorporating measurement-based care, for patients with behavioral health and other general health comorbidities that have been shown to reduce overall healthcare costs.

Researchers – Positives:
-- integrated digital data allows continuous, large-scale assessment of the effect of medical-behavioral interventions on patient outcomes, and iterative testing of care and payment models and new technologies.

Policymakers – Positives:
-- digital integrated health records and data collection give a more complete picture of population health enabling targeted policy interventions and the delivery of whole person healthcare.

-- quality measure dashboards can inform public reporting and accreditation programs with real-time behavioral health integration indicators.
-- all of the benefits listed above will enhance overall clinical, social, and economic outcomes across the healthcare community.

Technology Developers – Positives:
-- integrated dQMs create incentives for EHR and analytic vendors to improve their products in terms of behavioral data capture, interoperability and presentation.
-- behavioral health apps, wearables and digital therapeutics can feed structured (as opposed to narrative) data back into EHRs to support measurement and higher quality of care.

Q3. *What are the potential benefits, challenges and unintended consequences associated with https://www.sportingnews.com/us/nfl/news/full-nfl-schedule-2025-dates-times-channels/6d81968a8b9b081e63193cb3----------*

Preface: While digital, integrated medical-behavioral health quality measurement holds significant promise, it may also introduce unintended consequences that policymakers, providers and developers must anticipate and mitigate against.

POSSIBLE UNINTENDED CONSEQUENCES & MITIGATION STRATEGIES:

-- Avoidance of High Risk Patients - if payment is tied strictly to dQMs, practices may avoid high-risk, complex, comorbid patients whose behavioral needs make targets harder to meet, yet who are the patient cohort most in need of integrated, whole person care. MS: deploy appropriate risk adjustment methods.
-- Too Rigid Measures/Over-Measurement – overly rigid measures could discourage experimentation in care delivery innovations or culturally tailored approaches. MS: pair process metrics with patient-reported outcome measures (PROMS) and qualitative context); engage patients in the dQM design phase.
-- Metric Proliferation – multiple organizations (CMS, NCQA, State Medicaid agencies) may have similar not identical integrated measures eroding provider buy-in. MS: engage frontline clinicians in dQM design; align multiple programs to one core measure set).
-- Incomplete or Poor Quality Data - reliance on incomplete or poor quality data; behavioral health data are often sparse, inconsistent or recorded in free text (unstructured), relying on such data can misrepresent care quality. MS: expand standardized behavioral data elements in the United States Code for Data Interoperability (USCDI); include validation periods before linking dQMs to payment.
-- Digital Measures Prioritizing What Is Easy to Codify - such as PHQ-9 repeated within 12 months, over what matters most to patients such as functional improvement, leading to 'treating the metric' rather than the person.
-- Algorithmic Bias – automated scoring can amplify disparities if data reflects unequal documentation patterns, such as under-coding behavioral conditions in minority populations.

MS: stratify dQMs to identify disparities early.
-- Measurement Fatigue – requiring extra documentation to satisfy measure logic may perhaps lead to more time for coding for quality measures and less time on patient engagement, or can lead to small behavioral practices with limited EHR capabilities struggling to meet dQM reporting requirements, thus widening the gap between medical and behavioral sectors in this area. MS: concerns mitigated by application of evidence-based, measurement-informed practices, which should become an essential training component for all providers.
-- Accidental Data Exposure – can erode patient trust and confidence, and, if patients fear broader data sharing, they may under-report behavioral symptoms or decline screening, reducing care quality and data accuracy. MS: Implement granular consent and data segmentation and strengthen governance; engage patients and advocates in dQM design.
-- Unauthorized Data Re-Use – digital QM datasets re-used for research, payment or surveillance in ways patients did not anticipate or consent to, can raise ethical concerns.

Q4. *What processes or outcomes will be measurable using FHIR-based dQMs that are not currently measurable?*

PROCESSES AND OUTCOMES NEWLY MEASURABLE USING FHIR-BASED dQMs:

Preface: FHIR (Fast Health Interoperability Resource-based digital quality measures allow data to be followed-up with questions, exchanged, and computed directly from standardized EHR elements, including behavioral health and patient-generated data, in real time. This allows new categories of measurement that are not possible, or highly burdensome, to capture with just claims or chart abstraction.
Below is an overview of processes and outcomes that could become measurable when FHIR-based dQMs and integrated medical and behavioral EHRs are widely implemented.
We suggest this could be framed around the Donabedian Model of: (a) Structure: e.g. EHR requirements, provider training, organization accreditation); Process: e.g. Wagner Chronic Illness Care Model, and (c) Outcomes.

Whole Person, Cross-Domain Processes of Care:

A. Integrated Screening and Follow-Up – rates of adults with chronic medical conditions also receiving standardized depression or anxiety screening and documented follow-up; rates of patients with depression who receive metabolic screening (glucose or lipid testing when on antipsychotic medication) since FHIR enables linking of structured BH assessments (PHQ-9, GAD-7 etc) with lab and medication data across systems.
B. Bidirectional Referral and Care Coordination – proportion of behavioral health referrals with closed-loop communications; average time from referral to first completed BH visit, since FHIR allows event-level tracking of referrals and response across organizations, not now visible in claims data.
C. Team-Based Care Processes – frequency and timeliness of care manager contacts in collaborative care models; percent of patients with depression who had at least one

psychiatric care review documented, since FHIR resources can document an timestamp multidisciplinary interactions in structured form.

Patient-Reported and Patient-Generated Data Integration:

A. Continuous Behavioral Outcome Tracking – changes in behavioral validated scale scores aggregated automatically into quality measures e.g. depression remission at 12 months since FHIR resources can store repeated, codified assessments directly in the EHR rather than buried in text notes.
B. Digital Therapeutics and Wearables – medication adherence or sleep/activity patterns among patients with depression or anxiety as part of outcome tracking. FHIR allows inclusion of patient-generated health data from apps and devices.
C. Patient-Reported Outcome Measures (PROMs) – functional status, quality of life, and social participation outcomes linked to integrated care, FHIR allows direct capture and scoring of PROM results through standardized resources.

Social and Environmental Drivers of Health:

A. Upstream Drivers of Health – percent of patients screened for food, housing instability, or social isolation using standardized tools; proportion of positive screens with documented referral to community-based resources; improvements in behavioral or physical health outcomes following community resource engagement, linking clinical and community service data supports outcome tracking beyond the clinic.

Longitudinal and Outcome-Oriented Measures:

A. Cross-Setting Continuity of Care – post-discharge behavioral health follow-up within 7 days after ED or inpatient visit; hospital readmission rates among patients with comorbid depression or substance use disorder.
B. Functional, Recovery-Oriented Outcomes – return-to-work, school attendance milestones for patients receiving integrated behavioral health services; sustained remission or symptom improvement trajectories over time, rather than point-in-time metric; longitudinal data aggregation across multiple resources allows continuous tracking of patient-level outcomes.

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