

Behavioral Health Information Sharing

Behavioral Health Information Sharing Advisory Group

The Oregon Health Authority (OHA) is focused on developing a strategy to support integrated care and services by enabling the electronic sharing of behavioral health information between providers. This is a critical step in supporting the coordinated care model, and realizing the goal of better health, better care and lower costs for everyone. The Behavioral Health Information Sharing Advisory Group was created to spearhead this work.

People served

The advisory group will develop products to assist providers in determining when behavioral health information can be shared without consent, and work to clarify misconceptions and confusion about applicable state and federal privacy laws that may currently limit information sharing.

Working with state stakeholders and federal partners, the group will seek to understand how widespread the use of information sharing is among providers and attempt to minimize the barriers providers face when sharing information. The advisory group will use existing solutions, or develop new solutions, to encourage the electronic sharing of behavioral health information.

Protecting a patient's personal health information is the most important goal. OHA is committed to making sure that the right systems are in place to protect personal health information. Though electronic information sharing is important to improve care coordination across providers, the advisory group's solutions will ensure that there are safeguards in place to protect patients/consumers.

What's changing?

As the state and providers begin to integrate the delivery of behavioral and physical health, it will be important to be able to share health information between providers to make sure that care is coordinated well for patients.

Many providers are exchanging behavioral health information through non-electronic means but fewer providers share behavioral health information electronically because of misconceptions about the restrictions imposed under state and federal laws, Electronic Health Record incompatibility, and limited knowledge about existing technological solutions. Because providers do not fully understand the laws about information sharing, there is a missed opportunity to provide the highest level of coordinated care.

Many providers in the state would like guidance about behavioral health information sharing and the intersection of state and federal law, especially around information sharing of substance use diagnoses and treatment.

Behavioral Health Information Sharing

Benefit to clients and community

- Electronic information sharing between providers supports better overall care for patients and eases transitions between health care settings.
- Information sharing ensures that providers are able to make informed decisions/assessments about a patient's care given their medical history. Because of information sharing the quality of care, safety and effectiveness of provider recommendations improve.
- Improved information sharing through the use of existing technology solutions developed by the Oregon Health Authority.
- The Oregon Health Authority will better understand providers' needs and collaborate with them to develop long-term solutions that improve behavioral health information sharing.
- Providers will better understand federal and state law, including that state law supports information sharing for purposes of treatment, operations, payment and health oversight purposes.

System Impact

There are obstacles that limit information sharing between physical and behavioral health providers. If we want to improve health outcomes for all Oregonians, we need to create solutions that allow providers who are delivering care to share information while still protecting the patient's privacy. Developing a common strategy and approach to information sharing will allow CCOs and other providers to provide whole-person care to their patients.

For Information regarding the Behavioral Health Information Sharing Advisory Group or its efforts:

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Visit the advisory group website – <http://www.oregon.gov/oha/amh/Pages/bh-information.aspx>

OHA Behavioral Health Information Sharing Advisory Group
2015 Provider Survey
Summary and Analysis

In February 2015, the Oregon Health Authority (OHA) Behavioral Health Information Sharing Advisory Group circulated a survey to providers throughout the state of Oregon. The survey aimed to help OHA understand the challenges and barriers that providers and Coordinated Care Organizations (CCOs) face when sharing patient health information, including behavioral health diagnoses and treatment.

The internal Advisory Group will use the responses from the survey to further develop a strategy to support integrated care and services and enable the sharing of behavioral health information between physical and behavioral health providers.

Additional information about the Behavioral Health Information Sharing Advisory Group is available at the following page: <http://www.oregon.gov/oha/amh/Pages/bh-information.aspx> or by contacting Veronica Guerra (veronica.guerra@state.or.us) or Stephanie Jarem (stephanie.jarem@state.or.us).

Information on Survey Participants

The online survey was distributed widely via CCOs, professional organizations, health systems, health information exchanges, and other interested parties. There were 138 responses; below is a highlight of the survey responders:

- 54% self-identified as a behavioral health provider (34% mental health provider, 13% substance abuse or addictions provider, and 7% mental health and substance abuse)
 - 13 % identified as a primary care provider, and 33% marked “other.”
- 71% practiced in an urban setting
- 76% are providers within a CCO network
- 63% practice in a behavioral health clinic or a primary care practice with integrated behavioral health care
- 91% exchange a patient’s personal health information with other providers in order to support service and care delivery, including care coordination and planning between providers

Barriers and challenges to exchanging patient health information

Part of the survey was dedicated to understanding the particular issues that providers encounter when trying to share patient information electronically with other providers.

- Many providers still use non-electronic means to exchange patient health information.
 - 87% of providers still utilize fax machines, 91% use phone calls, 68% use secure email/online tool, and 9% share information verbally or in-person.
- Nearly half of participants are “rarely” or “never” able to exchange any type of patient information electronically (see Table 1).

Table 1: Frequency of electronic information exchange by type of health data

Question 2: How often are you able to exchange each type of patient information electronically?	Type of health diagnoses/ treatment			
	Physical health	Mental health	Substance abuse/addiction	Oral health
Always able to exchange electronically	9.4%	8.7%	3.6%	3.6%
Sometimes able to exchange electronically	29.7%	26.1%	12.3%	9.4%
Rarely able to exchange electronically	21.8%	26.8%	26.8%	12.3%
Never able to exchange electronically	24.6%	30.4%	43.5%	35.5%
Unsure	14.5%	8.0%	13.8%	39.1%

Top three “major” barriers to electronically sharing behavioral health information among providers:¹²

1. Confusion over compliance with state or federal laws (44%)
2. Concerns over privacy and confidentiality protection for the patient (38%)
3. State or federal laws prohibit the type of sharing that is needed/wanted (37%)

Other identified “major” barriers to electronically sharing behavioral health information included:

Internal technology systems don’t capture behavioral health data appropriately	33%
Concerns over liability if info shared is later shared inappropriately	31%
Unable to separate out behavioral health info when sharing patient records	28%
Lack of proper consent forms from the patient	25%

Survey participants were invited to identify additional barriers or to elaborate on the challenges faced when trying to share behavioral health information electronically. Participants shared additional technical, cultural, and legal barriers that they have encountered.

Resources and Possible Solutions

Majority of providers have not received any guidance or assistance on this issue (61%), and half of participants indicated that they do not have a reliable source of information or reference on this topic area. The survey identified a number of possible solutions, including some technological, legal, and educational ideas.

Top three solutions or resources that would be “very helpful” to providers in addressing barriers to electronically sharing behavioral health information:³

1. Improved technological solutions for easier sharing (75%)
2. Design of a model or universal consent form (64%)
3. Continued advocacy for federal action on changes to 42 CFR Part 2 requirements (54%)

¹ Behavioral health data includes mental health, substance abuse, and addictions health information.

² Other possible answer choices included “somewhat of a barrier,” “not a significant barrier,” and “N/A”

³ Other possible answer choices included “somewhat helpful” and “not helpful”

Other solutions or resources that would be “very helpful” to providers included personalized assistance or support for your organization (39%), information on how others have tackled similar issues (39%), and an instructional webinar about applicable state/federal laws and common misconceptions (38%).

Survey participants were invited to identify additional solutions or to elaborate on available resources. Participants shared potential legal, technical assistance, and technological solutions.

Analysis

This provider survey offered a brief and limited snapshot into the current issues, barriers, and solutions of electronic behavioral health information sharing. When interpreting the survey responses, there are a number of points that stand out.

- **Provider concerns are not specific to *electronic sharing*.**
Nearly half of survey participants said that they are “rarely” or “never” able to electronically exchange any type of patient information. The three most significant barriers identified were related to concerns with compliance, privacy and confidentiality, and the restrictions in the law itself, unrelated to technological capacity. Additionally, there were consistent concerns that *other* providers were incorrectly sharing information. Providers and organizations need clarity on how, when, and with whom information can be shared, in an easily-digestible format. Everyone would benefit from clearer language and education on the subject.
- **Solutions must be inclusive.**
Provider knowledge, health system capability, and the level of health information technology varies across the state. Any proposed solutions will need to be all-encompassing and include options for those that may not have robust technological systems or capacity.
- **Mismatch of barriers and solutions.**
Overwhelmingly, survey participants indicated that improved technological solutions for easier sharing would be very helpful. This does not directly match up with the identified barriers, which focused on legal concerns and might necessitate further education. A clearer understanding of the specific technological needs is required. For example, one provider may simply need general access to electronic record keeping, while another may have specific difficulties, such as combining or separating mental health and addictions patient information within the EHR system.
- **Education is needed.**
Some of the identified barriers (confusion over compliance) may be due to the actual restrictions in 42 CFR Part 2 that aim to protect the confidentiality of the patient. These restrictions are unlikely to change, and may continue to make information sharing an intricate and complex process that requires providers to become knowledgeable about the applicable state and federal laws.

Oregon Health Authority
Office of Health Information Technology
Health Information Technology Oversight Committee
HIT/HIE Community and Organizational Panel (HCOP) Charter - DRAFT
December 2014

Objective	
The HIT/HIE Community and Organizational Panel (HCOP) is to facilitate communication and coordination among CCOs, HIOs, and other healthcare organizations and to provide strategic input to the Health Information Technology Oversight Committee (HITOC) and Oregon Health Authority (OHA) regarding ongoing HIT/HIE strategy, policy, and implementation efforts.	
Panel	
Sponsor: Susan Otter, Director of Health Information Technology, OHA	
Members:	Staff:
<ul style="list-style-type: none"> • TBD 	<ul style="list-style-type: none"> • Marta Makarushka, Office of HIT, OHA • Justin Keller, Office of HIT, OHA
Scope	
The HIT/HIE Community and Organizational Panel will be comprised of representatives from a variety of Oregon organizations actively engaged in implementing or operating HIT/HIE initiatives.	
Activities for this Panel include:	
<ul style="list-style-type: none"> • Share and discuss Panel members’ HIT/HIE implementation efforts and experiences to: <ul style="list-style-type: none"> ○ share best practices, ○ identify common barriers ○ identify opportunities for collaboration ○ assist the OHA and HITOC in gaining a better understanding of real-world HIT/HIE implementation efforts • Identify opportunities for HITOC to consider regarding providing guidance and/or developing policy to address barriers or better support HIT/HIE efforts in Oregon • Provide insights to OHA regarding OHA’s statewide HIT/HIE initiatives, concerns or implications for implementation, and opportunities for improvement and support 	
Initial topics for consideration by the HCOP could include:	
<ul style="list-style-type: none"> • Governance models • Sample data sharing agreements <ul style="list-style-type: none"> ○ Data use ○ Privacy/security • Consent and privacy issues • 42 CFR Part 2 and behavioral health sharing 	
Though the Panel will not be responsible for preparing formal recommendations to HITOC or OHA, the Panel’s collective input may influence HITOC recommendations or OHA efforts.	
Duration and Schedule	
It is anticipated the Panel will convene in early 2015 and meet quarterly, unless the membership determines a different meeting schedule would better suit the needs and purpose of the group. All meetings will be public meetings.	

Membership

The Panel will be comprised of entities leading community and/or organizational HIT/HIE implementation or operations such as CCOs, local or regional HIOs, health plans, health systems, and other partner organizations. A guiding principle for panel composition is the inclusion of a broad representation of organizational roles, including technical, operational, and policy.

Though the Panel is not limited to a certain number of organizations or efforts having a representative, it is expected that one organization-identified representative will join the Panel as an ongoing member, attending and participating consistently over time.

Initial recruitment will include both (1) invitations sent to eligible organizations that OHA is aware of, and (2) an open invitation to recruit eligible nominees from the broader statewide HIT/HIE community of which OHA may not be aware. Recruitment will be ongoing in order to allow for the inclusion/addition of future Panel members who may become eligible at a later date.

Technology vendors are not eligible to participate as Panel members.

Guiding Principles

The goal of this Panel is to discuss direct experiences with HIT/HIE implementation and operations based on which the Panel may put forth suggestions to the HITOC and input to OHA for consideration. This group is not, however, tasked with creating technical solutions or making policy recommendations.

OHA is vendor-neutral and will therefore not endorse any particular vendor. The HCOP venue is not intended to be used for advertising or marketing products on behalf of vendors.

HITOC's HIT/HIE Community and Organizational Panel (HCOP)
Themes from First Meeting
May 21, 2015

The first meeting of the Health IT/Health Information Exchange Community and Organizational Panel (HCOP) was held on May 21, 2015. The focus of the first meeting was to provide a forum for the panelists to share information on their HIT/HIE project to inform their colleagues and to identify challenges and opportunities that have been identified thus far. Panelists include:

- Gina Bianco, *Acting Executive Director, Jefferson HIE*
- Pat Bracknell, *Executive Director, Central Oregon Health Connect*
- Stephanie Mendenhall, *Service Integration Manager, Community Connected Network*
- Klint Peterson, *Project Manager, RHIC*
- Deborah Rumsey, *Executive Director, Children's Health Alliance*
- Susan Kirchoff, *Consultant, Oregon Health Leadership Council*
- Britteny Matero, *CareAccord Director, Oregon Health Authority*

The 'Themes' below are a high-level compilation of the ideas that were expressed during these discussions. The 'Comments' noted for each theme are thoughts that were shared by the various panelists in the process of the discussions. As such, this is not a comprehensive list representing all the panelists' input on each theme. This list of themes offers the HCOP a starting point for identifying relevant topics for future meetings. The list is not in any particular order (e.g., of importance, priority). The topics identified for discussion at the second meeting include policies that impact security, privacy, and information sharing, as well as a look at the broader state and federal policies that impact HIT/HIE work.

Themes	Comments
Opportunities	
Broad Stakeholder Support	<ul style="list-style-type: none"> • JHIE has broad stakeholder involvement in their Board and committees. [Gina Bianco] • We started by asking potential users what they wanted—centralized directory for social services for referral purposes and a registry of clients being served in common were prioritized. [Stephanie Mendenhall] • We started this process by asking providers what they wanted—the providers wanted more information about where their patients have been and what treatments are being provided. This need is particularly relevant for new Medicaid patients that are assumed to have a medical history. [Klint Peterson] • [CHA's tool] arose organically from the provider side—the provider wanted to see a more holistic view of the patient as they incorporated care management and population management in their practices; additionally. [Deborah Rumsey]
The multitude of use cases that are possible	<ul style="list-style-type: none"> • There are a multitude of high-value use cases right now including: EMS/paramedics for information at the point of care in emergency response; care coordination across the care team; reporting. [Klint Peterson]
Challenges	
Value Proposition and Buy-in/Adoption	<ul style="list-style-type: none"> • Value has to be demonstrated to users on the ground—particularly if it leads to an extra step in their work flow. [Gina Bianco]

	<ul style="list-style-type: none"> • Marketing is needed to get folks to buy into the system. People have been burned by big data systems before and this just feels like one more database. [Stephanie Mendenhall] • We want health care providers to anticipate using this new tool – so we put time into branding, marketing and creating awareness. All of our partner organizations have a prioritized list of projects to complete. We want this project to be very visible and high on their list of priorities. The focus must remain on patient care. [Klint Peterson]
Variability in EMR vendor capabilities & costs	<ul style="list-style-type: none"> • The costs that vendors charge for turning some of these capabilities on vary significantly. [Gina Bianco] • For Direct secure messaging: some vendors require a CCDA attachment to send (tied to meaningful use requirement); others require users of Direct to have an NPI number. [Brittney Matero] • The ICD 10 delay pushed the vendors’ readiness back. There are a lot of different EMR vendors and their capabilities are very different. [Deborah Rumsey]
Lack of clarity around policies for security/privacy/information sharing	<ul style="list-style-type: none"> • Without clear guidance on federal laws like 42 CFR part 2, we are subject to different interpretations by each individual organization’s attorneys. [Gina Bianco] • The inability to share certain categories of mental health information limits a physician’s ability to serve a patient holistically. As a Mental Health provider, we want to be able to share that information in order to move towards unified treatment plans. [Stephanie Mendenhall] • Every individual organization has its own interpretation. We have a working approach and are vetting that with partners. Each partner decides whether to withhold certain types of data based on their own interpretation. [Klint Peterson] • Connecting to behavioral health providers and information is desperately needed. [Susan Kirchoff]
Training and Work Flow Issues	<ul style="list-style-type: none"> • The transition of care process is often outside of the user’s workflow and the magnitude of data required by the meaningful use standard does not always add value to providers. HIE adoption is a change management process which takes time. We spend a significant amount of time training users on appropriate (HIPAA compliant) use of the system, and monitor use to quickly identify issues. [Gina Bianco] • Even with electronic tools and transport mechanisms (e.g. Direct secure messaging), people do not know where to send things – because they lack an address book or directory for providers outside their organization. [Brittney Matero] • It takes time to do this right—it requires the building of trust. Taking this time is costly. [Klint Peterson] • Metrics that incentivize providers to use certain tools need to make sense for existing work flows so that value/buy-in are not threatened. [Susan Kirchoff] • Training happens in stages, and practices are at varying states of readiness to incorporate in their workflow. It can be a very long process. [Deborah Rumsey]

Strategy and Scope of Efforts	<ul style="list-style-type: none"> • Keeping up with the many use cases and staffing new technologies is a challenge. [Gina Bianco] • The scalability and cost structure of this long-term is a challenge. [Stephanie Mendenhall] • There is a concern that existing notifications efforts may lead to providers receiving three identical notifications for the same patient event. There needs to be some level of coordination across these projects. [Klint Peterson] • People want [EDIE] to be more than it is—it is challenging to communicate to stakeholders what the tool does and does not do. [Susan Kirchoff]
Data and Technical IT Challenges	<ul style="list-style-type: none"> • A big challenge is the integrity of the data and managing errors—how to identify them and how to handle this once they are identified. [Klint Peterson] • The integrity of the data can be a challenge, as well as the normalization of data. Standards can be interpreted multiple ways. We are building our own [data specs] because we work with pediatricians and most of the existing standards are based around adult chronic conditions. [Deborah Rumsey]

HCOP Panel Projects Overview

Project Name	HCOP Panelist Name	Organization	Project Type	Region	Vendor	Financing/ Governance	Incorporated Data Types	Users	Identified Use Cases	Implementation Status
Jefferson HIE	Gina Bianco	Jefferson Health Information Exchange	HIE	Southern Oregon, Columbia Gorge	Medicity	501c3, broad stakeholder representation on Board, hospitals vetted the vendor	Labs & Pathology, Radiology reports, transcribed reports, cardiology studies, care team list, automated HL7 Admit Discharge Transfer (ADT) feeds, care summaries	Live: Providers, Hospitals, Clinics/FQH CS, CCOs; Future: Other Labs/Diagnostics, First Responders, Pharmacies, Registries, Other Health Plans	Closed Loop Clinical Referrals, Direct Secure Messaging, Community Health Record, Hospital notifications, Transitions of Care	Phased Implementation: Phase 1: Referrals and Direct SM (completed) Phase 2: Community health record (completed), planned integration with EDIE Phase 3: Population Health Mgmt; Analytics
Community Connected (C2) Network	Stephanie Mendenhall	Jackson County Health and Human Services	HIE	Jackson County	VistaLogic	CCOs put in costs, matched by HHS	Behavioral health, Social service data, Court data, School district data, employment	HHS – Mental Health, DHS, Medical Providers, CBOs, other HIEs	Central contact registry/referral service, auto-populated forms, access & utilization notifications, data aggregation & reporting	Vendor contract signed—in development

Project Name	HCOP Panelist Name	Organization	Project Type	Region	Vendor	Financing/ Governance	Incorporated Data Types	Users	Identified Use Cases	Implementation Status
Care Team Link (Regional Health Information Collaborative; RHIC)	Klint Peterson	InterCommunity Health Network CCO (IHNCCO)	HIE	Lincoln, Benton, Linn Counties	Intersystems Product - HealthShare	CCO funded (IHNCCO)	EMR encounter data, claims data, pharmacy	IHNCCO affiliates	Care history for coordination, Hospital notifications, order tracking (closed loop prescriptions), Emergency Preparedness	Vendor contract signed. IT work on claims data has been implemented (currently updating nightly) Real-time Encounter feeds are being received from area hospitals. Data feeds from other partners are in-process.
CareAccord	Britteny Matero	Oregon Health Authority	Direct Secure Messaging Provider (HISP)	Statewide	Harris, Mirth Mail	Medicaid and state funded, currently offered for free	N/A – Direct is a transport mechanism, allows for sharing of a broad range of data	Oregon health care entities, providers and care team members, state agencies (OHA/DHS)	Direct secure messaging use for care coordination across organizational and geographical boundaries; EMR-integration pilots will support Meaningful Use requirements for sending Transitions of Care summaries	Web portal currently operational, about to engage in EMR-integration pilots

Project Name	HCOP Panelist Name	Organization	Project Type	Region	Vendor	Financing/ Governance	Incorporated Data Types	Users	Identified Use Cases	Implementation Status
Care Management, Analytics & Reporting Tool (CMART)	Deborah Rumsey	Children's Health Alliance (CHA)	Population Management Tool	Portland Metro Area	Wellcentive	Provider-Purchased, providers vetted the vendor	EMR data (varies by vendor), EDIE, payer claims data	CHA member Pediatricians (100+)	Robust data aggregation, analytics, and reporting, pay for performance analytics, care management supports, shared care plans.	Vendor contract signed; development work for pediatric content ongoing; 2 EMR Interfaces complete; 1 health plan interface complete; EDIE interface complete, asthma registry complete.
Central Oregon Health Connect	Pat Bracknell	St. Charles Health System	HIE	Central Oregon	N/A	Governance and financing structure created – currently considering next steps for technology efforts	TBD	CCO, St. Charles Health System, community providers, etc.	TBD	Data foundation for HIE created—will determine further efforts in the future
Emergency Department Information Exchange (EDIE)	Susan Kirchoff	Oregon Health Leadership Council	Hospital Event Notification System	Statewide (for Hospitals)	Collective Medical Technologies	Costs shared: half by hospitals and half by commercial plans/OHA on behalf of CCOs. Representative Governance Committee	Automated HL7 Admit Discharge Transfer (ADT) Information, supplemented by manual entry of care guidelines/history	<u>EDIE:</u> Oregon and WA Hospitals <u>PreManage:</u> Medical groups, health plans, CCOs, other care coordinators	Hospital notifications, shared care guideline/history	EDIE Utility almost at full participation (95%) for ED and inpatient ADT Information, PreManage expanding across user types

Topic Areas Identified on Member HCOP Interest Forms

Security/Privacy

- Address privacy/security issues to break down barriers to HIE
- Oregon specific security and privacy discussions
- Interpreting state and federal law regarding behavioral health data exchange
- Defining and simplifying HIPAA rules
- Data Sharing Agreements – what is and what is not allowed?
- Consent Models
- Dispelling myths to help promote broader information sharing opportunities
- Breaking down barriers to exchange health information with entities caring for children/families

Implementation

- Adoption Strategies
- Use case prioritization and development
- How to position the data repository for metrics?
- Platforms to allow secure exchange of information from a variety of sources between PCPs and Specialists; health plans and providers, and hospitals and providers; etc.
- HIEs and population health management: considerations for data exchange and secondary use

State Services/Goals

- Developing use cases for integrating EDIE/PreManage with HIE services to create a more streamlined and coordinated user experience.
- Exploring opportunities to integrate OHA services and registries into HIE services
- Alignment with healthcare transformation goals and CCO activities
- Governance strategies at the state level
- Create messaging around information sharing benefits to influence legislative action

Fiscal

- Funding models for sustaining organizations
- Developing a standard ROI
- Seeking opportunities to gain economies of scale for implementing HIE technologies/interfaces where there is overlap across regions or with State initiatives

Provider-centric

- Allowing access to data at the provider level
- Lessons learned – what is or is not valuable to be viewed by a clinician?
- Simplified information sharing processes for providers
- Better coordination between health care and social service providers
- Availability and accessibility of population management platforms to all providers
- High EHR vendor cost to providers

Consumer-centric

- Eliminating redundancy for consumer and recognizing the importance of Trauma Informed Care
- Consumer engagement opportunities and best practices
- Simplified access to medical and social services for consumer

Telemedicine

- Integrating remote monitoring devices into HIE data exchange services.

Other

- Disparate application of ONC standards regarding interfacing with EHRs