



ASET

Arizona Strategic Enterprise Technology

**Arizona Health Information Exchange (HIE)
Unconnected Providers Program**

**HIE ENVIRONMENTAL SCAN
BEHAVIORAL HEALTH CARE**

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During the fall of 2012, the Arizona Strategic Enterprise Technology (ASET) Office commissioned a series of interviews and an HIE environmental scan to better understand the adoption and use of health information technology, and health information exchange, in Arizona.

The HIE environmental scans of the three specific healthcare segments: Behavioral Health Care, Long Term Care, and Rural Health Care, covered activities associated with the federal government, at the national level, within Arizona, and within other states. The scans reviewed publicly available resources.

The interviews were conducted during August and September of 2012 with 32 individuals representing 19 organizations. These organizations were chosen to provide representative views of Behavioral, Long Term Care, and Rural providers and to elicit information concerning their adoption and use of health information technology and exchange in Arizona. An Arizona HIE environmental scan is included to provide perspective.

This report addresses the Behavioral Health Care environment.

*All of the reports can be downloaded from the ASET website at
<http://hie.az.gov/it.htm>*

*Arizona HIE Environmental Scan and Community Interviews
HIE Environmental Scan – Behavioral Health Care
HIE Environmental Scan – Long Term Care
HIE Environmental Scan – Rural Health Care*

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Background

Arizona has a rich history of promoting health information technology (HIT) and health information exchange (HIE). In 2006, community leaders came together and developed the Arizona Health-e Connection Roadmap. The Roadmap identified the priorities for healthcare network services and created a business plan that focused on meeting the needs of health care providers, payers, patients, consumers, and employers.

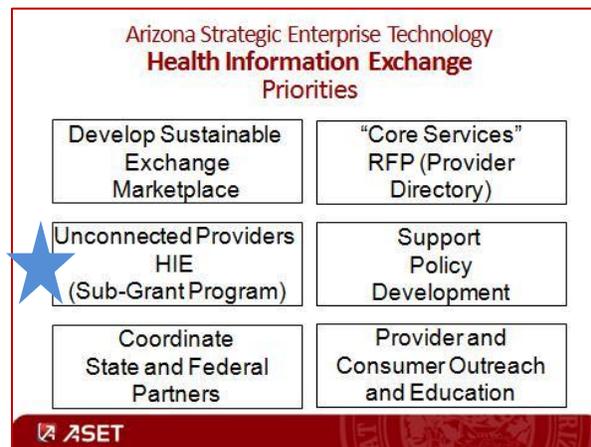
In 2009, Congress passed the American Recovery and Reinvestment Act (ARRA). A key piece of this legislation was the Health Information Technology for Economic and Clinical Health (HITECH) Act. This Act established Meaningful Use (MU) of interoperable EHRs in the health care system as a critical national goal and it incentivized EHR adoption by providers.¹ Health information exchange (HIE) has emerged as a core capability required for both hospitals and providers to achieve MU, qualify for the incentive programs, and provide better care for patients.

Another key element of the HITECH Act was the State Health Information Exchange Cooperative Agreement Program (SHIECAP). This program assists states and territories to advance regional and state level HIE; while moving toward national interoperability of patient health information.²

In March 2010, the State of Arizona was awarded a \$9.3M SHIECAP grant. The Grant is provided as a catalyst to develop the necessary infrastructure for Arizona’s health information exchange capability. The Arizona Strategic Enterprise Technology (ASET) office is responsible for the programmatic implementation of this grant for the State of Arizona.³

In responding to the grant award, ASET formed an HIE Steering Committee to continue the momentum of the work done in 2006 which created Arizona’s Health-e Connection Roadmap. The Committee continued to leverage community resources and relationships, establish priorities for the grant funds, and provide on-going review and feedback of the grant program.

In the fall of 2012, ASET launched the **Unconnected Providers’ Grant Program**⁴ to support HIE planning and implementation for health care organizations. This grant program is aimed at stimulating the adoption of HIE by healthcare providers who currently have not planned or implemented an information exchange solution. It has a special focus on rural hospitals and providers, behavioral health providers, and long term care providers. To help prepare for this grant program, ASET commissioned an environmental scan of current health information exchange initiatives in Arizona and around the country and interviews with Arizona healthcare providers.



Introduction

In the United States, an estimated 57.7 million adults experience a behavioral health disorder annually.⁵ A growing problem, it is projected that by 2020, behavioral health disorders will exceed all physical diseases as a major contributing factor to disability worldwide. Also, behavioral health is highly associated with co-morbidity in the chronically ill, specifically for patients with diabetes and cardiovascular disease. In addition to behavioral health, substance abuse accounts for an estimated \$510.8 billion in societal costs annually within the United States.⁶

The Office of the National Coordinator (ONC), the Substance Abuse and Mental Health Service Administration (SAMHSA), Health Resources and Services Administration (HRSA), along with several private initiatives, have recognized the necessity of including behavioral health and substance abuse treatment data in Health Information Exchange (HIE). These groups have created programs and pilots to address behavioral health and substance abuse treatment data exchange through HIE mechanisms.

Health Information Technology (HIT) and HIE have the potential to greatly increase the quality of, and access to, care for many individuals affected by behavioral health and substance abuse disorders. Despite this potential, the majority of behavioral health and substance abuse treatment providers lag behind their medical counterparts in the adoption of these technologies. One of the contributing factors to slow adoption is the exclusion of a large portion of behavioral health and substance abuse treatment providers in recent healthcare reform incentive initiatives. In the Health Information Technology for Economical and Clinical Health Care Act (HITECH), which is a part of the American Recovery and Reinvestment Act (ARRA), clinical psychologists, psychiatric hospitals, clinical social workers, and mental health and substance abuse treatment facilities are left out of these program incentives. Upfront financial costs, lack of IT support staff, and the costs of maintaining EHR systems account for further barriers to implementation.⁷ In addition, the stringent requirements of Electronic Code of Federal Regulations 42 CFR Part 2 (42 CFR Part 2) create hurdles in the integration of substance abuse data in HIE.

Despite these roadblocks, many organizations are forging ahead with efforts to integrate behavioral health and substance abuse treatment data into their HIE model. Profiled in this document are the efforts of private and public organizations that participate in the electronic exchange of healthcare information and their efforts to integrate behavioral health and substance abuse treatment data.

This document describes a variety of pilots and programs which Arizona can use to leverage “best practices” for the residents of the state. Not every case study profiled is a functional HIE. Rather, each case study presents a set of attributes that provide valuable insight into the use of HIE to support behavioral health and substance abuse treatment.

Summary of Findings

Federal Initiatives

There are several federal pilots and initiatives focused on including both behavioral health and substance abuse treatment data in HIE. These programs focus on the integration of sensitive data through the use of the following:

- DIRECT Message services
- Creating standardized approaches to protect sensitive healthcare data
- Developing and enforcing a set of national standards and protocols relating to the exchange of healthcare data
- Providing financial incentives for behavioral health organizations and substance abuse providers to participate in HIE
- Developing technical assistance solutions to help behavioral health and substance abuse providers implement and maintain HIT
- Developing education opportunities and guidance to behavioral health organizations and substance abuse providers to assist in the integration of HIE

National Programs

National initiatives are currently focused on the integration of behavioral health and substance abuse treatment data in HIE through multiple pilot projects. Key concepts from the initiatives include:

- The need to develop exchange protocols across state lines that respect federal and state initiatives.
- The need to integrate primary and behavioral health exchanges
- The importance of common platforms to exchange data
- The need to standardized methods to collect data across state lines
- The importance of developing a continuity of care document
- The importance of supporting e-prescribing across state lines

Legal

Both HIPAA and 42 CFR Part 2 require that the electronic exchange of sensitive data to be protected in the following manner:

- Organizations must develop requirements for the disclosure of sensitive healthcare data
- Patients must be provided consent and restriction mechanisms for the disclosure of their healthcare data to providers
- Organizations must implement safeguards to protect patient identity

At this time, most EHR systems do not have the capacity to manage the necessary requirements for patient consent or mechanisms to successfully comply with the re-disclosure of select types of information as required by 42 CPR Part 2.⁸

States

Across the nation, HIEs are preparing to participate – or are participating – in the exchange of behavioral health and substance abuse treatment information. While each HIE functions differently, several common practices were identified:

- Information must be shared, bi-directionally, across the continuum of care and be accessible to appropriate provider groups.
- DIRECT messaging can serve as a secure platform to assist HIEs in the exchange of behavioral health and substance abuse data.
- HIEs must work to coordinate care amongst all providers.
- All stakeholders will need to have access to education, information, and best practices to successfully engage in the exchange of information.
- Patient privacy and consent is a critical component in the sharing of sensitive healthcare data.
- Patients need to be informed and educated on their rights relating to their personal health information.
- Behavioral health and substance abuse data providers must have access to the complete care record to effectively coordinate care amongst their patients.
- Behavioral health and substance abuse treatment providers need to be included in HIE governance structures.
- States and federal regulatory bodies should revisit patient privacy laws and amend them to allow better integration of behavioral health and substance abuse treatment data in exchange records.

Recommendations

The following outlines the best practices for the exchange of behavioral health and substance abuse treatment data within an HIE. These are based upon recommendations and practices from existing HIEs.

Streamline Privacy and Consent Processes

- Create standard approaches to protect sensitive healthcare data.
- Create common standards for the sharing of Behavioral Health information.
- Clarify the consent required for sharing behavioral health information.
- Implement safeguards to protect patient identity.
- Provide transparent consent mechanisms for patients to disclose the use of their healthcare data.
- Implement mechanisms to limit the access of sensitive patient data to specified providers and entities.
- Develop exchange protocols across state lines that respect both federal and relevant state regulations.
- Educate patients on their rights to their personal health information.
- Provide data segmentation and metadata tagging options in EHRs to screen and protect sensitive healthcare data.

Provide HIE Related Incentives to Behavioral Health and Substance Abuse Treatment Providers

- Provide financial incentives to behavioral health and substance abuse treatment providers to participate in HIE.
- Develop technical assistance solutions to help implement and maintain behavioral health and substance abuse HIT systems.
- Develop technical workforce to support behavioral health and substance abuse treatment IT infrastructures.
- Develop education opportunities and guidance to assist in the integration of HIE into Behavioral Health workflow.
- Include behavioral health and substance abuse treatment providers in HIE governance structures.
- Develop legislation and incentive programming to train behavioral health and substance abuse providers in HIE/HIT.

Environmental Scan: Federal, National, and Legal

This section provides an overview of federal programming, national pilots, and legal considerations that impact the way HIEs share behavioral health and substance abuse treatment data.

Federal Initiatives

Several federal programs and resources are working to integrate behavioral health and substance abuse treatment data into HIE.

SAMHSA HIT Initiative

The SAMHSA HIT Initiative, in a partnership with ONC, works to develop a coherent HIT strategy to ensure that behavioral health provider networks successfully adopt health information exchange and EHR technology. To facilitate this, SAMHSA provides leadership to the behavioral health community with specific emphasis on creating HIE between behavioral and primary healthcare practices. The initiative focuses on the following goals⁹:

- Develop an infrastructure for interoperable EHRs, including privacy, confidentiality, and data standards.
- Use national forums to disseminate HIT strategies to State and Territorial behavioral health authorities, providers, consumers, families and other stakeholder groups.
- Provide incentives and create tools to facilitate the adoption of HIT and EHRs with behavioral health functionality in both general and specialty healthcare settings.
- Deliver technical assistance to State HIT leaders, behavioral health providers, patients and consumers, and others to increase adoption of EHRs and HIT with behavioral health functionality.
- Enhance capacity for the exchange and analysis of EHR data to assess quality of care and improve patient outcomes.
- Increase the percentage of behavioral health organizations/providers that adopt and use certified electronic medical records by 2013.

Behavioral Health Clinical Quality Measures Interagency Workgroup for Meaningful Use Criteria

ONC created a workgroup consisting of 18 federal agencies which was tasked with creating consensus recommendations that focused on increasing behavioral health related clinical quality measures in the criteria for the Meaningful Use Stages 2 and 3. The recommendations focus on the inclusion of quality measures in the following domains: alcohol, drug use, depression, suicide, trauma, and autism.¹⁰ The project was scheduled to conclude on September 30, 2012 and final recommendations will follow in the subsequent months.

Behavioral Health Roundtable

In July 2012, ONC conducted a daylong roundtable meeting to discuss the use of health IT to integrate primary care and behavioral health services. The meeting included both private and public stakeholders representing: consumers, providers, payers, HIEs, professional associations, vendors, health IT certification organizations, and federal agencies.¹¹ During the roundtable, the participants focused on priorities and approaches to create bidirectional communication and fluid information sharing of behavioral health and substance abuse treatment data. Participants offered a wide range of inputs including focus areas, recommendations for action, and suggestions for completing those actions.

The follow represents a list of recommendations developed during the session:

- Include clinical decision support (CDS) for behavioral health screening and treatment in EHRs.
- Include clinical quality measures in Meaningful Use that complement the use of CDS for screening and treatment.
- Provide explicit guidance on how primary care (eligible provider) EHRs should handle behavioral health-related data.
- Engage behavioral health providers in defining additional data elements needed in continuity of care document (CCD) to support behavioral health.
- Continue endorsement of DIRECT for behavioral health providers who have not adopted EHRs.
- Ensure EHRs can support development and sharing of a Wellness Recovery Action Plan (WRAP).
- Develop standards for referral management.
- Promote the development of standards for behavioral health assessment tools.
- Incorporate discrete fields into certified EHR technologies for behavioral health data.
- Provide clear strategies to increase EHR adoption among behavioral health providers, including means to accessing financial and technical resources. Encourage vendors to develop low-cost systems.
- Use prior health IT adoption experiences to inform development for behavioral health and primary care integration use cases.
- Provide technical assistance to behavioral health providers who adopt EHRs.
- Develop a certification for behavioral health EHRs.
- Use challenge grants to improve access to care.
- Identify and disseminate best practices from organizations that have successfully integrated behavioral health and primary care.
- Support provider education for proper handling of behavioral health data, especially in relation to substance abuse data and consent to disclose and re-disclose data.
- Provide guidance on the impact of, and practices for, incorporating patient-generated health data into EHRs.
- Educate behavioral health patients on treatment and privacy decisions using clear language.
- Promote the development of health IT systems to facilitate peer support.

Prescription Drug Monitoring Program

The Enhancing Access to Prescription Drug Monitoring Programs Project is a joint effort that is sponsored by ONC, SAMHSA, the Center for Disease Control (CDC), and the Office of National Drug Control Policy. The purpose of this program is to create health IT mechanisms that increase timely access to data in an effort to reduce prescription drug misuse and overdose.¹² During a roundtable discussion, the program identified the following as key questions, issues, and policy considerations in leveraging existing technology to improve monitoring of prescription medication:¹³

- Harmonize data messaging and formatting standards for communicating with interstate data exchanges.
- Develop standards for the user interfaces and identify the prescription drug monitoring program (PDMP) data elements and formats in which data will be presented in the EHR.
- Develop standards for the user interfaces and identify the PDMP data and format in which it will be presented in pharmacy systems.
- Review state laws and current policies for PDMP use of intermediaries.
- Review state laws relative to the delegation by the pharmacist to the pharmacy and the physician to the hospital.
- Review current policies and practices for “Dummy BINs” (Batch ID Numbers) that will route pharmacy dispensing data, including cash payments and recommend policies for same.
- Review current policies and practices relative to role based access to pharmacy and ED systems to ensure data is only available to authorized personnel and recommend policies for same.

Veteran’s Administration: Data Segmentation for Privacy Initiative

In conjunction with SAMHSA, the Veteran’s Administration (VA) developed a pilot program to test standards-based management, exchange, adjudication, and enforcement of privacy consents, as services to exchange privacy protected records. The pilot successfully transmitted “identified” privacy-protected clinical records that include: automated data tagging, purpose of use, data confidentiality, data sensitive, data segmentation, and compliance with HL7.¹⁴

The demonstration was developed as a part of the Data Segmentation for Privacy Initiative (DS4P). The purpose of the pilot was to allow providers to share portions of an EHR while excluding other information, particularly information related to substance abuse treatment. More specifically, the pilot allows the implementation and management of disclosure policies that originate from the patient, a regulatory body, or an organization, in an interoperable manner within an HIE environment. Records include health information protected by metadata classification “tags” indicating confidentiality, sensitivity, and patient directives. This allows individually identifiable health information to be appropriately shared for the following reasons: patient treatment and care coordination; third party payment; analysis and reporting for operations, utilization, access quality, and outcomes; public health reporting; population health; technology assessment; and research.¹⁵

National Initiatives

There are several national programs that support the inclusion of behavioral health and substance abuse treatment data in HIE.

Behavioral Health Data Exchange Consortium (BHDEC)

In 2010, ONC created the Behavioral Health Data Exchange Consortium (BHDEC). BHDEC joined Florida, Michigan, Kentucky, Alabama and New Mexico to develop a common set of exchange procedures and policies in compliance with 42 CFR Part 2 and the individual state statutes. During this pilot, the participating states conducted a DIRECT-enabled demonstration using policies and procedures that align with the technology used to execute the exchange of information. In addition, the pilot tested the ability of the components to respond to real-world use case scenarios. This project is still in process and has yet to issue a final report.¹⁶

Behavioral Health – Medicaid Information Technology Architecture (BH-MITA)

States vary widely in the extent of their collaborations across State mental health (MH) and substance abuse (SA) agencies (referred together as behavioral health (BH) agencies), with external BH agencies, and the State Medicaid agency. In an effort to narrow these gaps, the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) entered into a joint project to adapt the Medicaid Information Technology Architecture (MITA) planning tools and processes for BH activities. The goal of this project was to facilitate greater coordination, cooperation, and interoperability among agencies, programs, and systems at both the federal and state levels.

The BH-MITA¹⁷ project developed key elements of a BH Business Architecture, describing the needs and goals of State BH agencies and a collective vision for the future, including:

- Concept of Operations
- Maturity Model
- Business Processes Model
- State-Self Assessment Tool

Open Behavioral Health Information Technology Architecture Project

The Open Behavioral Health Information Technology Architecture (OBHITA), in collaboration with CONNECT, demonstrates how behavioral health providers can improve outcomes and the overall quality of care through seamless integration with primary care networks and statewide HIEs. The OBHITA project will work to achieve the following: establish a common platform for states to manage safety-net services network; share the lessons learned during this demonstration with other Behavioral Health IT developers; and standardize data collection and sharing processes while maintaining behavioral health-specific patient privacy regulations.¹⁸

The SAMHSA-HRSA Center for Integrated Health Solutions

The Center for Integrated Health Solutions¹⁹ (CIHS) promotes the development and integration of primary and behavioral health services. The efforts by the center are a part of SAMHSA HIT and Integrated initiatives.

Through a cooperative agreement, select State Designated Entities (SDEs) receive funding to develop infrastructure that supports the electronic exchange of health information among behavioral health and primary healthcare providers. Participating states in this program include: Oklahoma, Rhode Island, Kentucky, Illinois, and Maine. More details regarding individual state efforts can be found in the “Environmental Scan: States” section of this document.

In addition, CIHS provides training and technical assistance to 64 community behavioral health organizations, community health centers and other primary care and behavioral health organizations that collectively receive more than \$26.2 million in Primary and Behavioral Health Care Integration grants.²⁰ Overarching goals of this project include:²¹

- Develop and implement infrastructure to share behavioral and physical health records,
- Review and make recommendations on elements specific to behavioral health to include in a Continuity of Care Document (CCD),
- Work on processing consent directives in ways that comply with federal and state laws,
- Incorporate lab results into infrastructure as structured data, and
- Support the use of electronic prescribing.

The National Council for Community Health

The National Council for Community Health (The Council) is a national organization that focuses on the needs of behavioral health organizations across the nation. In June of 2012, The Council conducted the *HIT Adoption and Meaningful Use Readiness in Community Behavioral Health* survey amongst behavioral health and substance abuse treatment providers. The survey collected the responses of over 500 behavioral health organizations that answered a variety of questions pertaining to the implementation of EHRs and meeting Meaningful Use standards.²² The following is a list of recommendations reported from respondents:

- Congress should pass the Behavioral Health Information Technology Act (S. 539), which provides behavioral health organizations with the same financial incentives as their medical counterparts.
- ONC needs to provide targeted funding to behavioral health organizations in Beacon Community Grant programs where the behavioral health organization is the lead.
- All State Health Information Exchanges should include behavioral health organizations.
- Incentivize Regional Extension Centers to support behavioral health organizations.
- Expand the Community College Curriculum and the Health Information Technology Competency Examination Programs implemented by ONC targeted specifically to behavioral health organizations.

- Support a program specifically targeted to use products developed under the Curriculum.
- The U.S. Department of Health and Human Services should provide the infrastructure and resources for groups of behavioral health organizations to collaborate to improve access to care; exchange information; establish collaborative mechanisms to meet administrative, IT, and clinical quality objectives; achieve cost efficiencies; and negotiate with public and private payers — similar to the Health Center Controlled Networks that have assisted health centers in EHR adoption.
- EHR vendors should provide lower cost entry-level systems that focus on care coordination and health information exchange with the data being portable to any EHR in the future.

Legal Initiatives

The exchange of healthcare data typically first requires some kind of patient consent – either opt-in where the patient specifies consent to sharing of information – or opt-out – where the information will be shared unless the patient actively requests to be excluded. Maintaining privacy protections, and the acquisition of consent in the sharing and/or withholding of healthcare information, has been a challenge in the development of HIE, particularly as it relates to issues of “sensitive healthcare data.”ⁱ

While states have differing privacy and consent laws, they are all subject to overarching federal regulations. It is beyond the scope of this document to review each law relating to the disclosure of behavioral health and substance abuse treatment data. Rather, select regulations are presented that affect the electronic exchange of behavioral health and substance abuse treatment data. The two principle privacy and consent federal regulations that govern HIE as it relates to the sharing sensitive data are:

Health Insurance and Portability and Accountability Act (HIPAA) – Privacy and Security Rule²³

Privacy Rule: The HIPAA Privacy rule provides a basic, federal level of health information privacy protection. More specifically, the rule protects all “individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral”. The rule assures individual patient rights to health information, imposes restrictions on uses and disclosures of protected health information, and provides for civil and criminal penalties for violations. The Privacy rule applies to health plans, healthcare clearinghouses, and healthcare providers who conduct electronic financial and administrative transactions that are subject to standards as determined by HHS. It also allows the application of state law in place of the federal HIPAA standards if state law is stricter.

Security Rule: This portion of HIPAA works in conjunction with the Privacy rule for the protection of healthcare information inclusive of: administrative, physical, and technical safeguards. This rule protects a subset of information covered by the Privacy Rule, including “all individually identifiable health information a covered entity creates, receives, maintains, or transmits in electronic form.” In addition, the rule requires covered entities to protect patient’s health records and other identifiable health information by requiring organizations to set limits and regulations on the way in which information is used and disclosed.

ⁱ Due to the nature of this report, “sensitive healthcare data” will refer directly to behavioral health and substance abuse treatment data. The definition, however, is often inclusive of information pertaining to HIV/AIDS statuses, genetic information, reproductive health, domestic violence, sexually transmitted diseases, sexual orientation, professional statuses, and relationship statuses.

Electronic Code of Federal Regulations 42 CFR Part 2

This regulation was enacted to ensure that information related to substance abuse treatment is kept private. 42 CFR Part 2 is applied broadly to both freestanding programs and those which are a part of larger organizations. To be subject to 42 CFR Part 2, an entity must be federally assisted and/or advertise as “providing, alcohol or drug abuse treatment or referral for treatment, or prescribe controlled substances for the detoxification or maintenance treatment of substance abuse.”²⁴

The regulation prohibits the disclosure of substance abuse patient records and information that identifies an individual as an alcohol or drug abuser without obtaining the written consent, per each instance of disclosure, of the individual. Any information that may be used to identify a patient is protected by this regulation and all permissible disclosures are limited to information necessary to carry out the purpose for the disclosure. The regulation also prohibits anyone receiving information from substance abuse programs from disclosing it without informing the patient in writing.²⁵ 42 CFR Part 2 establishes limited circumstances in which disclosures are permitted without the consent of the patient such as for: medical emergencies, audit/evaluation activities, and research. Other disclosures without patient consent are permitted with an authorizing court order issued by a court of competent jurisdiction.²⁶ 42 CFR Part 2 permits patient information to be disclosed to health information organizations (HIOs) and HIE systems.

Environmental Scan: Arizona Behavioral Health Care

Nationally, individuals that suffer serious mental illness (SMI) who are served by public mental health systems die 25 years earlier than members of the general population. In the state of Arizona, individuals who suffer a serious mental illness and seek treatment in public healthcare facilities, die at an even higher rate, on average, 30 years earlier than the general population. Of these deaths, 60% result from an associated chronic illness.²⁷

Arizona Accountable Care Organizations (ACOs), Health Information Exchanges (HIEs), and Telemedicine Initiatives

Arizona has a rich history of promoting HIT and HIE. As a result of prior state and community efforts, there are many initiatives – taking various forms – currently underway to share health information electronically. While there is HIE activity in the state of Arizona, very few are exchanging behavioral healthcare and substance abuse treatment data. The following pilots and programs describe efforts within Arizona to exchange behavioral health information electronically. The examples noted below are specific to behavior health care.

A full report describing other ACO, HIE, and Telemedicine initiatives, **Arizona HIE Environmental Scan and Community Interviews**, can be downloaded from <http://hie.az.gov/it.htm>.

HIE Initiatives

In addition to the ACO-related initiatives, there are several other HIE activities currently taking place, or under development, within the state.

Bayless Behavioral Health Solutions²⁸

In 2011, Bayless Behavioral Health Solutions launched a statewide HIE that focuses on the exchange of behavioral healthcare data. They were one of the first mental health providers to launch an HIE to share patient records with partners. Through a two-way, secure data exchange information is accessible to anyone involved in mental health services, including healthcare providers, insurance companies, case managers, educators, probation officers, and skilled nursing facilities. In compliance with state and federal security laws, sensitive data exchange within Bayless is not integrated with medical health records.

Community Access Partnership of Arizona and Mexico (CAPAZ-MEX); Cross-Border Continuity of Care Record project²⁹

CAPAZ-MEX is a joint program between Mexico and Arizona whose primary goal is to improve the health status of the medically-underserved populations by building and strengthening the infrastructure for a continuum of care (medical, dental, and mental health).

It is a private medical providers' discount network established by the Regional Center for Border Health, Inc.³⁰ and the Yuma County Medical Collaborative to increase the availability, accessibility, and affordability of healthcare services for the uninsured and underinsured residents of Yuma County. The medical provider network extends to the US-Mexico border communities of San Luis R.C., Sonora, Los Algodones, and Mexicali, Baja California. Members can receive up to 65% discount on healthcare services. Members are enrolled into a Continuity of Care Record-Health Information Exchange (CCR-HIE) that allows their medical information to be accessed on both sides of the border by the CAPAZ-MEX medical providers through a secure web-portal.³¹

Telemedicine Initiatives

East Valley Banner Hospitals³²

Banner Health began testing a new program that allows patients with behavioral health issues in hospital Emergency departments to “see” a psychiatrist via a secured video link in late 2011. Using “Telepsych,” an emergency physician can request a consult from a psychiatrist or psychiatric nurse practitioner at the Banner Psychiatric Center, a 24/7 behavioral health center in Scottsdale, Arizona. When the secure video link is established, the psychiatrist works with the physician to assess the patient and can create a course of action for proper patient care.

Northern Arizona Regional Behavioral Health Authority (NARBHA)

NARBHA provides telemedicine for a network of small behavioral health clinics throughout the region (Mohave, Coconino, Apache, Navajo, and Yavapai).³³ This new form of mental health delivery receives financial support from the federal government, particularly from Medicare.

State Supported Public-Private Collaborative Initiatives

Arizona Health-e Connection Roadmap

In 2006 Arizona developed the Arizona Health-e Connection Roadmap³⁴. This roadmap has provided the foundation for many of the HIE initiatives within the state. The roadmap described an overall approach for connecting Arizona healthcare providers and in many cases, focused specifically on the health information exchange that would be required among providers within a medical trading area (MTA) as well as across the state. The Roadmap called out specific legal issues to address the appropriate handling of “special” behavioral health information that requires greater confidentiality protection – and the definition of the information that would be subject to the greater confidentiality restrictions.

Arizona Health eConnection (AzHeC)³⁵ – Regional Extension Center

In April 2010, AzHeC was awarded a grant by the Office of the National Coordinator for Health Information Technology (ONC) to develop a regional extension center (REC) to assist Arizona health care providers with EHRs and Meaningful Use. The Arizona Regional Extension Center (REC) is one of 62 federally funded and designated RECs nationwide that serves as an unbiased, trusted resource with national perspective and local expertise. The REC offers membership and “hands-on” technical assistance services to qualified health care providers.

Arizona Health-e Connection (AzHeC) administers the Arizona HIE Marketplace³⁶ program under the direction of the State of Arizona and the Arizona Strategic Enterprise Technology (ASET) office. This program provides viable HIE options to any willing Arizona health care provider and assists providers participating in secure exchange of health information.

AzHeC developed a marketplace for the DIRECT approach through services offered by health information service providers (HISPs). DIRECT is also known as a “push” technology as it will push data electronically – directly from one provider to another.

As of 11/29/2012, over 670 providers had established DIRECT Exchange secure messaging accounts. There are over 800 additional providers who have expressed interest and are going through the education and on-boarding process to establish accounts. Behavioral Health has been a participant in this project and has developed one of the use cases – “A behavioral health facility connecting with other providers, pharmacies, labs, and acute care facilities.”³⁷

The HIE Marketplace identifies and publishes information about health information exchange options, through an ongoing review and approval process, to ensure that Arizona health care providers are able to choose the best HIE option for their facility or practice. In 2013, AzHeC will be expanding the HIE Marketplace to review applications from organizations interested in being listed in the Provider Directory as “query based - robust HIE” in addition to the organizations already listed for “push - DIRECT HIE” capabilities.

State Initiatives

Arizona Department of Health Services (ADHS)

To better care for patients with behavioral health issues, the state of Arizona has begun implementing programs that coordinate and integrate care. The Arizona Department of Health Services (ADHS) Divisions of Behavioral Health Services, Public Health Services, and Licensing Services, as well as the Arizona State Hospital spearhead these activities, under a program called the Integration of Behavioral Health Care and Physical Health Care.ⁱⁱ The Arizona behavioral health hospitals and facilities are listed in the appendix.

In March of 2012, the Arizona Department of Health/Division of Behavioral Health solicited input from providers who serve individuals with general mental health (GMH), substance abuse (SA), or children regarding care coordination of services.³⁸ Forty-one providers participated in the forum. Comments and recommendations from the conference included:

- There is a systems issue - and cost - associated with care coordination that BH and PCP providers bear when it comes to care coordination. Technology has failed at bridging systems to provide an overall picture of a patient's diagnoses.
- Most providers were in agreement that some type of incentive process needs to be put in place for the care coordination process.
- Providers in general, agreed that lack of shared electronic records through the entire care coordination process hinders the system of care.
- Many providers were in favor of statewide health information exchange in order to improve care coordination for their members.
- Including social supports would improve relationships with non-behavioral health providers to advance care coordination while others expressed the need to build relationships with associations and use technology to provide better care coordination.
- Integrated electronic medical records including statewide health information exchange would improve care coordination.
- In the future, providers would like comparative data of the population as a whole in order to ID the outliers.

The Arizona Department of Health Services/Division of Behavioral Health Services – Regional Behavioral Health Authorities (ADHS/DBHS)

The ADHS/DBHS serves as the single state authority to provide coordination, planning administration, regulation and monitoring of all facets of the state public behavioral health system.³⁹ ADHS/DBHS contracts with community based organizations, known as Regional Behavioral Health Authorities (RBHAs), to administer behavioral health services throughout the state. The five RBHAs and their service areas are listed below:

ⁱⁱ The programs being explored employed a variety of approaches. For a more complete look at these programs please visit <http://www.azdhs.gov/diro/integrated/activities/index.htm>

- Magellan: Maricopa
- Community Partnership of Southern Arizona (CPSA): Pima
- Northern Arizona Behavioral Health Authority (NARBHA): Mohave, Coconino, Apache, Navajo, and Yavapai
- Cenpatico Behavioral Health of Arizona: La Paz, Yuma, Greenlee, Graham, Cochise, Santa Cruz, Gila, and Pinal
- Gila River Indian Community: Navajo Nation, Pascua Yaqui Tribe, White Mountain Apache Tribe of Arizona, and Colorado River Indian Tribe

Northern Arizona Regional Behavioral Health Authority (NARBHA) provides telemedicine for a network of small behavioral health clinics throughout the region.⁴⁰ While many people speak of mental health telemedicine in terms of improved access, equally important issues are continuity and longevity. Before telemedicine, patients in small towns would see a variety of psychiatrists. With telemedicine, it's possible to see the same psychiatrist. It provides the continuity that's important for the development of the therapeutic relationship. This new form of mental health delivery receives financial support from the federal government, particularly from Medicare. Mental health is now one of the four or five biggest uses of telemedicine technology in this country.

Arizona Organizations Supporting Behavioral Health Care

Arizona Psychological Association (AzPA)⁴¹

The Arizona Psychological Association promotes legislative and governmental action to advance the interests of psychology, psychologists, and the public in Arizona.

Arizona Psychiatric Society (APS)⁴²

The Arizona Psychiatric Society's objective is to continuously improve the ability of its members to provide quality psychiatric services to persons in need and their families. The APS participates in the APA legislative and public affairs networks.

Interview Summary

During August and September of 2012, interviews were conducted to inform the State of Arizona and the Arizona Strategic Enterprise Technology (ASET) office about the issues and opportunities facing health care providers regarding health information exchange (HIE). Behavioral health care providers were among those interviewed.

The interviews were structured to elicit information in three broad subject areas: Barriers to HIE; Drivers of HIE – those things that motivate participation; and Assistance needed to move forward with HIE. The interviews revealed a wide variety of comments in each subject area, which were grouped into categories within each specific area. Those categories that were mentioned most often are listed below:

Barriers to HIE

- Cost
- Insufficient Resources
- Lack of EMRs

Drivers of HIE Participation

- Better patient care
- Better relationships and hand-offs with other healthcare providers
- Required reporting

Assistance Needed for HIT/HIE

- Education / Outreach
- Expertise / Resources
- EMR Upgrades
- Interface development

The behavioral health stakeholders interviewed are sophisticated users of HIT and are ready to participate in HIE. They offered to help in thinking through the unique privacy issues surrounding the behavioral health data. There is tremendous value in access to both the physical and behavioral health information for a patient – especially medications. DIRECT will provide an early solution for behavioral health. It is important to develop a solution that doesn't require providers to go to more than one place for data.

The complete interview report, “**Arizona HIE Environmental Scan and Community Interviews**,” including all interview summaries, findings, and recommendations, can be downloaded from the ASET website at <http://hie.az.gov/it.htm>.

Environmental Scan: States

The following section describes initiatives in various states that provide examples of how behavioral health and substance abuse treatment data is being included in HIE activities.



Colorado

Colorado Regional Health Information Organization (CORHIO)⁴³

CORHIO is in the process of implementing the Behavioral Health and Health Information Exchange Project (Project) to better understand the opportunities and challenges of using HIT to integrate behavioral health and physical health data in HIE. The project is a collaboration of Colorado behavioral health organizations and healthcare providers.

The Project has described several points of interest for the exchanging of behavioral health data in HIE, inclusive but not limited to: connecting hospitals, state facilities, community centers, mental health centers, and primary care through bidirectional information sharing and the development of an accurate medication list and history shared bi-directionally from behavioral and traditional healthcare providers.

The Project is currently in its planning phases. A steering committee comprised of healthcare stakeholders and agencies have issued recommendations in support of the integrated healthcare of HIE and Behavioral Health. These recommendations include:

- Include the behavioral health community in the development of statewide health information exchange.
- Endorse a broader, statewide health integration agenda to promote better-coordinated, less fragmented care.
- Develop a communication and outreach plan that supports education for all stakeholders regarding HIE and targeted education for physical health professionals on working with the behavioral health community.
- Support revisions to public policy to address barriers to information sharing and partner with key constituencies, including advocating for a revision to restrictive federal substance use treatment program regulations.
- Modify CORHIO's Health Information Exchange (HIE) Operations
 - Develop a granular consent model.
 - Enable consumer access to treatment data to be available within the exchange.



Illinois

Behavioral Health Integration Project (BHIP)

Illinois was one of the five states to receive funding under SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) to create BHIP⁴⁴. The goal of BHIP is to promote the exchange of healthcare information among behavioral and medical providers. To accomplish this, the Illinois Office of Health Information Technology, the Department of Human Services and the Department of Healthcare and Family services along with multiple behavioral organizations have collaborated in a joint effort to develop a framework to govern the electronic exchange of data among these providers.

Under the framework, preliminary goals of BHIP include:

- Increase knowledge and ability to exchange data with physical health providers, as well as to adopt EHR.
- Develop a communication plan focused on engagement, education, and feedback.
- Research efforts inclusive of: a capacity study, best practices, and demonstration sites.
- Develop products such as: Mock CCD, consent forms, data architecture, agreements, and legislation.

BHIP will use DIRECT messaging to conform to both State and federal guidelines. Under Illinois law, patient consent forms must include: a receipt, a description of the purpose for sharing the information, what information can be shared, and the duration of said consent.⁴⁵ DIRECT will enable these requirements and allow patients to send sensitive healthcare data inclusive of behavioral and substance abuse treatment data. Through DIRECT, providers will also be able to send patient consent forms along with other healthcare forms, without the use of a particular EHR platform.



Kentucky

Kentucky Health Information Exchange (KHIE)

KHIE⁴⁶ was selected as one of five organizations to receive grant funding in support of integrating behavioral health providers in the state HIE through SAMHSA-HRSA Center for Integrated Health Solutions (CIHS). Specifically, the grant will be used to support the exchange of information between the healthcare providers and community mental health centers.

Currently, KHIE provides a baseline set of functions available across the state to support HIE. KHIE allows physicians to access patient health information directly from data input by other providers, hospitals, labs, and imaging centers. Components of KHIE include: a master patient index; record locator service; security; provider/user authentication; logging and audits; clinical messages and alerts; e-prescribing, patient demographics, lab order entry and results, radiology

and transcription reports, historical patient diagnoses, medications, procedures, dates of services, hospital stays, and access to the statewide immunization registry, ability to communicate reportable diseases and a provider portal.⁴⁷ Authorized users are able to use KHIE through a Virtual Health Record (VHR), a web-based portal.

KHIE operates on a “no-consent” model, meaning patient information can be included within the HIE without gaining specific patient consent.⁴⁸ This model is permissible based on the limited use of information permitted by the HIE, which includes the exchange of information for payment, treatment, and limited operation purposes. In addition, KHIE does not store patient health data and information is only available to providers upon request. Participating providers are responsible for managing sufficient safeguards and procedures in compliance with HIPAA and 42 CFR Part 2. Safeguards include; appropriate administrative, technical, and physical safeguards to prevent the unauthorized disclosure of data.

KHIE is currently in the planning phases of integrating behavioral and substance abuse data within its HIE.



Maine

HealthInfoNet⁴⁹

The state of Maine received funding by SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) that will aide in connecting 25 behavioral health organizations and 200 individual providers in the exchange of behavioral health data through HIE. Currently, providers exchange patient information inclusive of allergies, prescriptions, medical conditions, and lab and test results through HealthInfoNet. Behavioral health and substance abuse treatment data are not currently included in the state HIE.

Under the contract, HealthInfoNet will build the technical infrastructure needed to facilitate secure electronic record sharing of behavioral health data through the development of a secure, provider-only email. As a foundation, HealthInfoNet will build upon the collaborative recommendations previously developed by a statewide behavioral health information technology task force.⁵⁰ These recommendations are as follows:

- Plan for – and integrate – accountable care with HIE efforts
- Align laws and regulations with effective integrated care
- Maximize consumer participation and awareness
- Focus and simplify data sharing
- Encourage cultural change in provider organizations
- Significantly increase funding and incentives
- Develop tools and encourage use of best practices

In addition to the funding through CIHS, recent legislative changes will make it easier for behavioral health providers to participate in HIE. Specifically, Legislative Document 1331 (An Act to Increase Health Care Quality through the Promotion of Health Information Exchange and the Protection of Patient Privacy)⁵¹, passed by the Maine State Legislature in 2011, will permit patients to have choice in consent when sharing behavioral health data with selected providers through HealthInfoNet.



Nebraska

Electronic Behavioral Health Information Network

The Electronic Behavioral Health Information Network (eBHIN) serves as the RHIO for behavioral health providers in Southeast and Western Nebraska.

Through eBHIN, patient data is exchanged confidentially and seamlessly between providers across a secure network that provides complete, accurate, and searchable functionalities at the point of care.⁵² To do so, eBHIN uses a centralized data repository and standardized patient record exchange with the ability for the patient to consent to “opting in.”

The platform is HIPAA and 42 CFR Part 2 compliant. With written patient consent, information is pushed from the EHR to create a shared behavioral health record, accessible by other behavioral health organizations that are participating in the HIE. The data within the record may include any of the following data: emergency contact information, substance abuse history summaries, diagnosis information, insurance information, trauma history summary, current medication, allergies, employment information, mental health board disposition, living situation and social supports, and billing information. In order to participate in the HIE, patients must give consent that allows both the primary provider and any other provider in the network to access their data.



New York

Brooklyn Health Information Exchange

The Brooklyn Health Information Exchange (BHIX)⁵³ is a not-for profit RHIO that is aligned with the State Health Information Network of New York (SHIN-NY) and serves a diverse population of 2.5 million Brooklyn residents.

In 2011, BHIX began collaborating with primary care providers who jointly care for behavioral health patients to deliver continuity of care and wrap-around services – including medical, behavioral, housing, transportation and therapy.⁵⁴ BHIX integrates general and behavioral health information through a continuously updated Coordinated Care Plan that includes event

notifications and clinical messaging. Discharge data is available both to primary care physician and treating behavioral health provider within 24 hours of patient discharge.

Information accessed through BHIX includes both medical and sensitive data. When a patient provides consent to a medical provider to access information through BHIX, that provider will receive any and all information contained in the record, without regard to origin, provider, care received, date of care, or relevance to medical treatment.⁵⁵ Thus, consent automatically provides access to all information in the patient's record, including substance abuse treatment and behavioral health. To allow access to the information, patients have to provide their consent in writing.⁵⁶ Participating organizations must obtain patient consent separately to access community-wide information through BHIX.

HEALTHeLINK

HEALTHeLINK is a RHIO located in Western New York that connects physicians, behavioral health providers, hospitals, and insurance organizations.⁵⁷ As of 2011, the organization connected 1,890 providers with a total of 56,000 users.⁵⁸

Currently, HEALTHeLINK allows participants to receive lab results, radiology and hospital reports, directly into their EHR system through bi-directional connections.⁵⁹ Through the use of the HIE, treating providers are allowed to "pull" data, which has been consented by the patient including: labs, radiology, transcribed reports, medication history, and hospital admission and discharge details.

HEALTHeLINK is in the implementation stage of increasing the amount of providers using EHRs and improving communication between behavioral health and primary care providers for approximately 20,000 patients.⁶⁰ This was made possible by a HEAL NYⁱⁱⁱ 17 grant. The system will also provide decision support tools to enable practices to create proactive approaches to care by providing data at all necessary points of care. In addition, both primary care and behavioral health providers will be able to track and monitor behavioral health patient referral outcomes as well as provide education consulting to the primary care practice. A care coordinator will be assigned to provide continued follow-up education. Further plans look to integrate telemedicine to connect relevant providers with patients. Due to the strict requirements, HEALTHeLINK will not allow data for "pull" from federally qualified 42 CFR Part 2 facilities.⁶¹ The pilot is projected to launch in the latter part of 2012.

RecoveryNet

RecoveryNet⁶² is a collaborative of ten behavioral health providers that serve an estimated 111,000 patients in Rochester /Monroe County New York and is a part of the greater Rochester Health Information Organization (RHIO). It is one of the few HIE initiatives that share substance abuse data, as governed by 42 CFR Part 2 .The collaborative advocates for the use of community-based substance abuse treatment as a care option, ensuring the availability of high quality community- based alcohol and substance treatment in counties served by member agencies through the use of HIE.

ⁱⁱⁱ Health Care Efficiency and Affordability Law for New Yorkers

Within its HIE⁶³, the collaborative uses a uniform clinical document that tracks and measures outcomes amongst each partner agency as well as across the collaborative. RecoveryNet uses Netsmart Tier as its EHR platform to exchange information between providers and Monroe County's Addiction Recovery Employment System (ARES). ARES is a web-based application that links providers to the County Department of Social Services.

In addition to ARES, the collaborative received a HEAL NY 5 Initiative grant from the state of New York. The grant provides resources to set up and administer cloud-computing capabilities to RecoveryNet providers that do not have a local EHR. The grant also funds the implementation of a RecoveryNet IT helpdesk that provides support to partner agencies.

The collaborative is in the process of implementing a primary care and an OB/GYN clinic on site to open this fall. These clinics are poised to serve as referral services for patients being treated by substance abuse agencies and offer medical home services.



Pennsylvania

AlliedHIE

AlliedHIE⁶⁴, based in Harrisburg, PA, has launched a secure clinical messaging pilot HIE in partnership with Pennsylvania-based NHS Human Services⁶⁵. NHS is a nonprofit, multi-state collaboration, dedicated to the development and implementation of programs to provide care to children and adults facing addictions, autism disorders, intellectual and developmental disabilities, mental health issues, elder care, traumatic brain injuries, and foster care. AlliedHIE is utilizing a DIRECT and Health Information Services Provider (HISP) network to create secure messaging capabilities for the project.⁶⁶



Rhode Island

Currentcare

Currentcare⁶⁷ is Rhode Island's state HIE developed by the Rhode Island Quality Institute (RIQI)⁶⁸.

Over 254,000 state residents have given consent to have their individual information exchanged through Currentcare. Currently, the HIE exchanges lab test results, medications, and physician visit data through its HIE platform. The goal of this organization is to use information exchange to improve the quality of care and health outcomes for patients within their state; ensure information is exchange in a meaningful, lawful, and efficient manner; and educate patients on consent of healthcare information.

Currentcare was recently awarded a SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) grant to integrate behavioral health providers into their HIE. RIQI will lead the efforts in partnership with the Rhode Island Department of Health, the Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals, behavioral health community, general health providers, and Rhode Island Medicaid program. Specifically, the contract will fund the development of a necessary electronic infrastructure including: increasing provider enrollment in Currentcare; expanding access to Currentcare to behavioral health providers; gaining consent from patients to view clinical information, inclusive of lab results and medication history; sharing enrolled patient information between behavioral providers and general providers through secure data exchange; and connecting behavioral health and medical providers through DIRECT Messaging.⁶⁹

To gain access to patient information through Currentcare, patients must first grant their consent. Patient information cannot be accessed, released, or transferred from Currentcare without the electronic, written, or oral authorization of the patient. The patient is able to select one of three levels in granting consent of access to information: 1) authorization of all healthcare providers treating the patient, 2) authorization of named providers, or 3) authorization of healthcare providers that may care for the patient in emergencies or other unscheduled visits.⁷⁰

Consent for behavioral health data is built on current patient consent models. Substance abuse treatment centers are included in the expansion of Currentcare and must abide by 42 CFR Part 2. Specifically, patients consenting to the disclosure of substance abuse information must provide two separate consents: one consent allowing the treatment program to send information to Currentcare and a second consent allowing Currentcare to collect the information and provide it to those who are providing treatment or coordinating the patient's care.⁷¹



Texas

Texas Department of State Health Services: Clinical Management for Behavioral Health Services (CMBHS)

Clinical Management for Behavioral Health Services (CMBHS)⁷² is a Texas Department of State Health Services (DSHS) electronic health record system. The system combines automated health management systems from the former Texas Department of Mental Health and Mental Retardation (MHMR) and the former Texas Commission on Alcohol and Drug Abuse (TCADA) to create an automated client record system used to deliver services for the treatment of substance abuse, mental health, and co-occurring disorders.

The system uses role-based security that allows the sharing of information based on the patient consent. During a patient encounter, providers assist the individual in completing an electronic consent form. This form indicates which type of clinical documents may be released, to which providers, and a date range for access and expiration of consent. The data within the patient's record is separated by category, and stored as a separate document on a central database. As such, the system allows access controls to be applied to each data type, allowing the patient to

release the entire record or segment categories in order to exchange only specific data. Hard copies of the consent form are also completed, printed, and signed by the patient.

CMBHS was deployed December 14, 2009 and since, has been implemented across the state to DSHS-contracted substance abuse treatment service providers with the rollout finalizing in August 2010.⁷³ Prior to the initiation of CMBHS, DSHS used multiple record systems to capture and record healthcare data from various portions of the agency that did not communicate. Through the connectivity provided by CMBHS, mental health and substance abuse treatment providers are able to gather a more accurate treatment history; provide a comprehensive view of mental health and substance abuse services using integrated data; manage client care for persons with co-occurring conditions of mental health and substance abuse through the use of a single record system; reduce the inefficiency and costs associated the treatment of multiple distinct client information management systems for contracted community mental health and substance abuse services; and comply with state and federal mandates to integrate processes and procedures that guide the delivery of mental health and substance abuse services. Ultimately, the CMBHS system goal is to combine the electronic health recordkeeping requirements for both mental health and substance abuse treatment providers in a single system.

In addition to creating a publicly connected network, CMBHS developed a list of principles which they adopted to govern the exchange of behavioral health and substance abuse data.

Principles for Improving Mental Health Care in Texas through Technology⁷⁴

1. Health information exchange across a “network of networks” that includes locally controlled and state-managed information systems facilitate coordination of care, improve administrative processes, and simplify program oversight activities.
2. Clinical Management Behavioral Health Services (CMBHS) is intended to serve as a component within the state vision for health information exchange. CMBHS is intended to provide a single system for DSHS behavioral health contractors to provide and receive data about clients who receive, or have received, Texas Department of State Health Services (DSHS) sponsored behavioral health services. CMBHS is a key resource to support continuity of care across organizations including, but not limited to, DSHS-contracted providers, state hospitals, private health entities, and other state and local agencies.
3. Partners in the CMBHS-supported behavioral health information exchange network, including DSHS and the Local Mental Health Authorities (LMHA), will utilize national data standards where practical and collaborate on establishing and adopting best practices to facilitate health information exchange.
4. DSHS will consider service providers’ and LMHA’s resources, including staffing, technology, and funding, when developing and implementing technology services. There is a shared and joint responsibility to pursue resources from multiple sources and efficiently manage them to advance the use of health information exchange.

5. LMHAs are not required to utilize CMBHS as their Electronic Medical Record (EMR) for managing mental health clients. LMHAs will interface with CMBHS for reporting, data access, and certain care coordination purposes.
6. Automated information exchange across Mental Health and Substance Abuse (MHSA) contracted care providers will minimize duplicative administrative activities. The development and rollout of technology improvements is dependent on program goals and requirements, available funding, data standards, and providers' technological resources.
7. Any new functionality added to CMBHS should follow a collaboratively developed change management process. The description of functionality will include a justification for the functional change, information about the effect on client care, and applicable fiscal analysis. The timeframe for functionality change should provide adequate time for relevant technology and business process changes.



Utah

Integrated Justice Information System: Salt Lake City County

It is estimated that 80% of the individuals housed within correctional facilities have a substance abuse or behavioral health disorder history.

Many of these individuals are also frequent users of emergency and ambulatory care facilities.⁷⁵ Despite the concurrent use of both facilities, there is often a gap in the sharing of pertinent treatment data. In reaction to the escalating costs of healthcare and behavioral health services as a result of this cycle, Salt Lake County Utah developed an Integrated Justice Information System (IJIS) to better serve individuals within this community.

IJIS consists of three main methods to share information within the county: direct data exchange between agency systems, decision support systems for cross-agency data analysis, and a single point of access to information from IJIS agencies.

IJIS connects 35 behavioral treatment agencies with correctional facilities in order to better coordinate care for people within the population.⁷⁶ IJIS uses a subscription-and-notification service platform that acts as a data hub and connects information from various points along the criminal justice continuum. Behavioral health and substance abuse providers are able to directly log into correctional facilities and view “unsecured” information that could assist in care once the individual is released. Each time an individual logs onto the system, there is a blind notification sent to the relative facility and information is shared only with authorized users on a “right-to-know” basis. Users are also able to access application/status documents and static information. At this point in time, information cannot be exported from treatment providers to criminal justice subscribers; however, the system is looking to add bi-directional data exchange functionality. Through the use of this system, criminal justice agencies are able to better adjust

the type of sanctions that they administer, treatment providers are able to better manage and allocate resources when clients are detained, and individuals in program are able to better receive the continuity of care needed to successfully complete treatment.⁷⁷

Each individual receiving behavioral health or substance abuse treatment needs to sign a time-limited, revocable, waiver that allows specific entities to receive treatment information for a defined period of time. IJIS records these waivers, and creates an automated mechanism for sifting and publishing authorized information.

Summary - States

Across the nation, HIEs are preparing to participate – or are participating – in the exchange of behavioral health and substance abuse treatment data. While each HIE functions differently, several common practices were identified:

- Information must be shared, bi-directionally, across the continuum of care and provide access to necessary provider groups.
- DIRECT messaging can serve as a secure platform to assist HIEs in the exchange of behavioral health and substance abuse data.
- HIEs must work to coordinate care amongst all providers.
- All stakeholders will need to have access to education, information, and best practices to successfully engage in the exchange of information.
- Patient privacy and consent is a critical component in the sharing of sensitive healthcare data.
- Patients need to be informed and educated on their rights to their personal health information.
- Behavioral health and substance abuse data providers must have access to the complete care record to effectively coordinate care amongst their patients.
- Behavioral health and substance abuse treatment providers need to be included in HIE governance structures.
- States and federal regulatory bodies should revisit patient privacy laws and amend them to allow better integration of behavioral health and substance abuse treatment data in exchange records.

Appendix

Arizona Behavioral Health Facilities⁷⁸

Arizona Behavioral Health Hospitals

| Hospital | Location | County |
|--|-----------------|----------|
| The Guidance Center | Flagstaff | Coconino |
| Arizona State Forensic Hospital | Phoenix | Maricopa |
| Arizona State Hospital | Phoenix | Maricopa |
| Aurora Behavioral Healthcare – Tempe | Tempe | Maricopa |
| Aurora Behavioral Health System | Glendale | Maricopa |
| Banner Behavioral Health Hospital | Scottsdale | Maricopa |
| Haven Senior Horizons | Phoenix | Maricopa |
| Remuda Ranch Center for Anorexia and Bulimia, Inc. | Wickenburg | Maricopa |
| St. Lukes Behavioral Hospital, LP | Phoenix | Maricopa |
| UBH of Phoenix, LLC | Phoenix | Maricopa |
| Community Counseling Centers Inc. at Pineview Hospital | Lakeside | Navajo |
| Carondelet St. Joseph’s Hospital O’Reilly Care Center | Tucson | Pima |
| Sonora Behavioral Health Hospital | Tucson | Pima |
| Windhaven Psychiatric Hospital | Prescott Valley | Yavapai |

* Maricopa Integrated Health System (MIHS), previously known as Maricopa County, is classified as a short term hospital. MIHS is also the largest BH in-patient provider in the county.

Additional Arizona Behavioral Health Facilities⁷⁹

| Category | Number of Facilities |
|--|----------------------|
| Adult Therapeutic Foster Home | 25 |
| Juvenile Group Home | 87 |
| Level 1 Psych Hospital | 1 |
| Level 1 Residential Treatment Center | 8 |
| Level 1 RTC/Outpatient Clinic | 3 |
| Level 1 Specialized Transitional Agency | 1 |
| Level 1 Sub-Acute | 18 |
| Level 1 Sub-Acute / Level 2 Residential | 1 |
| Level 2 Residential | 153 |
| Level 2 Residential / Outpatient Clinic | 7 |
| Level 3 Behavioral Health Residential | 27 |
| Level 4 Rural Substance Abuse Transition | 7 |
| Level 4 Transitional Agency | 26 |
| Outpatient Clinic | 572 |
| Level 4 Rural Substance Abuse Transition | 2 |
| BH Unclassified | 1 |

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