NGA Center for BEST PRACTICES

Issue Brief

Health Information Technology Integration in Behavioral Health Care: Challenges, Best Practices, and Solutions for States

Executive Summary

The collection and exchange of health information has long been seen as a catalyst for improving the health care delivery system. Behavioral health is an integral component of overall health and is a practice area where health information technology (HIT) holds tremendous opportunities. Integrating HIT into behavioral health care facilities and allowing providers to effectively use it can lead to significant gains in supporting medication management, reducing discontinuity of care and establishing processes for tracking a range quality measures. However, integrating health IT efforts into behavioral health care settings presents unique challenges. This paper identifies and examines barriers to exchanging behavioral health information and ensuring patient privacy is protected. Several states have already begun to navigate those issues and can provide an early set of best practices and lessons for developing a strategy to implement HIT in the behavioral health care setting.

Many states are challenged to find funding to incentivize behavioral health providers to adopt HIT. In order to address that challenge, states may leverage purchasing and contracting authority to specify that behavioral health information technology be a requirement in provider networks and contracts. Some states have engaged private insurance plans to take similar steps. Additionally, states may consider exploring a mix of funding sources, including grants for Advanced Primary Care programs, to incorporate technology into behavioral health providers.

Behavioral health has often been segmented from the rest of the health care system. Coordination between different payers and providers can be complicated, making interoperability and standardization problematic. States may consider engaging behavioral health providers early as state HIT initiatives are being planned to ensure those providers understand the justification for health information exchange and to alleviate concerns about sharing behavioral health information.

Finally, state and federal patient privacy laws can create barriers to exchanging behavioral health information. Adhering to requirements for protected health information can be a looming challenge and prevent providers from sharing any behavioral health information. States may consider creating consent processes to allow data to flow to the appropriate providers, or may build consent into advanced directive registries to inform providers about whether they can access a patient's electronic health records at the point of care.

Despite the challenges, many states and behavioral health care facilities have taken steps to connect their systems to information exchange efforts. They recognize that behavioral health is a critical element of overall health; making it important to connect behavioral health treatment information to broader health information exchange efforts within the state.

Introduction to Behavioral Health in the States

Behavioral health conditions are one of the largest costs to state Medicaid programs, both in direct provision of care for behavioral health conditions and treating other co-occurring physical conditions that people with behavioral health may suffer from. In fact, behavioral health issues rarely occur in isolation; individuals with behavioral health conditions often have a range of other physical conditions, many of which are expensive chronic conditions such as heart disease and diabetes.[i] With Medicaid enrollment anticipated to increase as a consequence of the Affordable Care Act, behavioral health costs are expected to grow.[ii]

Behavioral health conditions, including mental health and substance abuse issues, influence how a patient receives care in any setting. Those include primary care settings where individuals are treated for depression, anxiety and other issues, and more costly residential or in-patient mental health facilities and substance abuse facilities that cater to those with severe mental health issues and substance abuse problems. Some of those facilities are state-run and operate almost solely from Medicaid revenue while others receive partial financing from Medicaid. Because of the substantial role that Medicaid plays in financing behavioral health treatment, patients with behavioral health conditions are among a state's most costly populations.

The providers offering behavioral health services include managed care organizations (MCOs), private practices, and community health centers. In the publicly financed health care system, including Medicaid, there is a clear lack of coordination among primary care doctors, hospitals, behavioral health practitioners, and other providers.[iii] That fragmentation problem may exacerbate other health and social problems for patients, and undermine efforts to improve overall health outcomes.

Behavioral Health and Care Coordination

Creating integrated health care systems that include behavioral health is challenging, but it is an important effort for states to undertake in seeking better patient outcomes and lower costs. Many of the most costly and complex patients have multiple physical conditions, in addition to behavioral health issues. The co-occurrence of a behavioral health condition in patients with the most common chronic physical conditions, including asthma, coronary heart disease, hypertension, diabetes, or congestive heart failure, is associated with health care costs that are 60 to 75 percent higher than those without a mental illness.[iv] Adults with a behavioral health condition and a chronic physical

condition have higher rates of hospitalization ranging from 46 percent higher for congestive heart failure to more than 70 percent higher for hypertension.[v]

Models of patient- centered care recognize the importance of ensuring that all patients receive the "indicated care when and where they need and want in a culturally and linguistically appropriate manner."[vi] The National Committee for Quality Assurance has measures of integration for accreditation as patient-centered medical homes (PCMH), requiring in 2011 that the health insurance plan collaborate with behavioral health specialists in triage decision-making and actively seek to improve coordination of behavioral health and general medical care.[vii]

Reforms at the state and federal level are leading health systems to more effectively integrate services by creating medical homes with multi-disciplinary care teams, including behavioral health specialists or community health workers, and aligning financial incentives across systems to encourage care integration. Facilitating the exchange of information across physical and behavioral health treatment systems is central to integration and can substantially improve care coordination and reduce health care costs.

Health Information Technology in Behavioral Health Care

Information technology in a behavioral health care setting can serve as a valuable tool for a patient's entire medical team, placing isolated episodes into context, and informing providers, and affecting the patient's entire health management plan. Providers can use electronic health records to support continuous care and monitoring, coordinate care between providers, and can be instrumental in identifying patients whose care should be escalated or modified. Integrating electronic health records and other health IT tools has the potential to extend patient care beyond the traditional clinical setting by integrating information streams with telehealth, social services, prison, and school-based health systems.

The Health Information Technology for Economic and Clinical Health Act (HITECH), established in 2009, provided $19 billion in incentive payments for providers and facilities that implement and demonstrate "meaningful use[viii]" of electronic health records. The incentive dollars were not intended to be on-going for providers and starting in 2015, providers will start to see Medicare payment adjustments if they do not employ electronic health records. The HITECH programs were designed to encourage the capturing and sharing of data, in hopes that analysis of clinical process and outcome metrics will eventually lead to improved health outcomes.

The law, however, does not include behavioral health facilities and providers among those eligible to receive incentive payments. If a facility—such as a mental hospital—has eligible providers (physicians, physician assistants, nurse practitioners, etc.) working within it, the eligible providers have the option to direct their meaningful use electronic health record (EHR) incentive payment to their facility. Additionally, providers who are giving mental health care inside an eligible facility—for example, a hospital with a mental health unit—are eligible to receive those payments.

A significant portion of those working with the most vulnerable populations (the severely mentally ill), are not eligible providers and their facilities are also ineligible for the incentive payments. Although those entities cannot receive incentive payments, that does not preclude them from incorporating certified electronic health records or other forms of HIT into their practices.

The HITECH Act required each state to designate an entity to develop and implement statewide health information exchange across the health care spectrum. But behavioral health facilities and providers may not be eligible to receive incentive payments from the federal government, though integration with existing state health information exchange efforts will be essential in order to deliver patient-centered care. Unique challenges and opportunities lie in tying those together. States, however, can take steps today in order to overcome barriers to a more coordinated delivery system of care.

Identified Barriers in Behavioral Health/State HIE Integration

Insufficient Funds

As states attempt to implement a strategy for incorporating behavioral health care facilities into existing state HIE efforts, they may find that funds are insufficient for the task. Additionally, as behavioral health providers and facilities are largely ineligible for incentive payments under meaningful use guidelines, persuading providers to invest in and use those systems may be challenging.

Segmented and Fragmented Behavioral Health Care System

Behavioral health care is segmented from the rest of the health care system, often provided to patients in specialized facilities that are isolated from the rest of the health care system. The behavioral health care system is also fragmented within itself. The fragmentation of funding mechanisms often involves a mix of state, local, private and federal funds that often make it difficult to maintain care quality and consistent financial incentives to encourage HIT adoption. In addition, the parallel systems of care—one for patients with Medicaid, Medicare, and private insurance, and another for patients utilizing entirely publically funded facilities—may influence how health IT efforts are adopted and used in practice.

Privacy and Consent

Navigating patient consent regulations poses a major challenge. In any medical practice area, careful consideration must be given to creating a balance between protecting consumers' sensitive health information and enabling appropriate provider access to electronic health information. In the case of behavioral health and substance abuse, the unauthorized disclosure of sensitive personal health information can be particularly critical because of the stigma often attached to mental illness and the possible legal entanglements related to substance abuse. State and federal laws provide a higher degree of protection for medically sensitive information, which includes some behavioral health information. In addition, state and territorial laws vary on the extent and under what conditions

medically sensitive information such as HIV status or treatment for substance abuse can be shared. Sharing information across state lines creates additional challenges and complexity to clinical information exchange as state laws relating to protected information vary with some states requiring more stringent standards for information sharing. These differences across states raise questions about which state's laws hold in a given situation, causing providers to be reluctant to participate in information exchange.

Identified Solutions and Points of Influence for States

Although the challenges may seem daunting, there are potential solutions some states have identified to address obstacles and provider incentives for behavioral health facilities and providers to work with state HIE efforts.

Seeking Out Alternative Funding

States may consider exploring a mix of funding sources that offer chances for states to develop a range of technology tools in behavioral health. For instance, states that receive grants from CMS to implement an Advanced Primary Care model (APC)[ix], also known as the patient-centered medical home, could emphasize health IT's role in helping patients to develop an individual care plan for behavioral health issues and coordinating with a patient's other providers.

Purchasing and Contractual Leverage

States may consider leveraging their role as major purchasers of health care services—through Medicaid and state employee benefit programs—to specify that behavioral health information technology be a requirement in provider networks and contracts.

A payer-driven model may be found in integrated health care systems such as Kaiser Permanente, which has invested heavily in web-based functionalities so that physicians, hospitals, and health plan administration can easily connect and coordinate care delivery. Functions comprised within systems like Kaiser Permanente's emphasize a continuum of care and can include electronic health records, electronic prescribing, and case management software, and clinical guidelines.

Nebraska has developed an information system tailored to interact with the behavioral health treatment system which became operational in the spring of 2011. The system, called the Electronic Behavioral Health Information Network (eBHIN). eBHIN will connect providers and participate in statewide health information exchange by connecting to the Nebraska Health Information Initiative (NeHII). That project has relied on a mix of mostly federal funds, including several grants from the Agency for Healthcare Research and Quality (AHRQ), a Rural Health Network Development Grant from the U.S. Health Resources and Services Administration (HRSA), as well as funds from Region V Systems and the Nebraska Information Technology Commission.

The Substance Abuse and Mental Health Administration (SAMHSA) features the deployment of HIT to support the treatment of substance abuse and behavioral health problems as a strategic initiative and priority, and has been actively involved in creating affordable, accessible and standardized clinical medical records through open source software. While there is an added benefit to open source software in its ability to structure consistent privacy standards across all users, legal requirements for privacy are still evolving, and interoperability of the system has not been accomplished at this point. SAMHSA is committed to sharing strategies for HIT implementation among states, and can offer lessons in incrementally aligning data processes with long term health system coordination goals.[x]

The **Oregon Community Health Information Network (OCHIN)** is a non-profit collaborative of community health centers with a combined database of nearly 1 million individual patients throughout seven states. OCHIN serves as the lead partner in Oregon's Regional Extension Center and provides practice management and electronic medical records software and services to community-based clinics. The network has pioneered the development of comprehensive HIT systems, including behavioral and dental health functionalities that enable providers to take an integrated approach to diagnosis and treatment. OCHIN accomplished that by developing a common health record for federally qualified health centers and hospitals, and fostering collaborations between county health departments and community health centers to enable them to buy a high quality health software package.

Engage Public and Private payers

States should engage private payers, large employers and business coalitions to develop policies that will encourage greater integration of behavioral health and HIE. Payers analyzing expenditures are quick to recognize that services and claims related to behavioral health are among the top five expenses. Similarly, the co-occurrence of mental health conditions with other conditions demands careful coordination of care and care transitions. Developing payment incentives across the public and private spectrum can magnify the effect and provide more encouragement for the integration of behavioral health with HIE efforts.

Provider Outreach and Adoption Incentives

Reaching community providers is an important step in deploying health IT systems across the delivery system, particularly in behavioral health which relies heavily on local services. Innovative outreach strategies may be necessary to encourage adoption and use in community clinics and among other

New York is using a community-based and provider-centric approach to behavioral HIT. The Health Care Efficiency and Affordability Law (HEAL), passed in New York in 2004, supports projects to accelerate the adoption of HIT and interoperable electronic health records. In particular, Phase 17 of HEAL awarded $120 million to community-based HIT projects to build a more streamlined approach to sharing patient information, with a focus on behavioral health and long-term care. One of the HEAL 17 initiatives allows the Regional Extension Adoption Center for Health (REACH) to create a new division of the extension center dedicated exclusively to behavioral health providers. The proposed project will utilize NYC REACH's existing HIT and interoperability infrastructure to facilitate health information exchange between designated mental health providers and existing Patient Centered Medical Home (PCMH)-qualified practices.

safety net providers, particularly those who treat substance abuse.

Nebraska has built a business model to support their HIT efforts. Their model relies in part on fees paid by providers. Recognizing the financial burden for providers in adopting EHR systems, their model includes subsidies for the costs associated with implementing the system and participating in statewide HIE. The participation fees are initially reduced and will increase incrementally over a period of five years.

Involvement with Other Health IT Efforts in the State

The Office of the National Coordinator for Health IT (ONC) has several existing grant programs in operation in every state. Regional Extension Centers and Beacon Communities each have a variety of activities with specific care delivery focal points. State HIT coordinators can reach out to the other ONC programs in their state to identify opportunities to leverage behavioral health efforts that may be underway or already in place.

Utilizing Resources to Navigate Privacy and Consent

States face confidentiality issues unique to behavioral health, as laws typically require a higher standard for consent before information can be shared. The HHS "Privacy and Security Framework for Electronic Exchange of Individually Identifiable Health Information" puts forth principles to guide health information exchanges, and includes the tenets of "openness and transparency" and "individual choice."[xi] While health information network plans typically promote features that allow patients to opt-out for general (non-specially protected) health information and opt-in for specially protected categories of health information, some states are exploring the feasibility of statutory changes to allow for a full opt-out consent model. The requirements of 42 CFR part 2, as it relates to substance abuse information, will have a significant bearing on crafting such a consent policy.

Virginia is planning to build consent into their advanced directive registry. These registries will allow providers to determine whether they can access a patient's electronic health records at the point of care.

Several other states have expressed interest in this developing this model as well.

States can support this process by seeking products that offer capabilities that allow sensitive health information to remain visible to authorized providers and invisible to other viewers. Finally, there is considerable confusion about the precise privacy laws relating to behavioral HIT. Targeted educational campaigns for providers may encourage adoption and use.

What's Next?

Connecting behavioral and physical health records may present a significant opportunity for community providers and health systems to develop a continuum of prevention, intervention, treatment, and support, to share clinical information and truly advance the concept of integrated and patient-centered care.

While national standards and capacity for HIT and HIE are evolving, and while efforts to forge a fully-integrated health care system continue, there are several actions states can take to lay a foundation on which further technical and process capabilities can continue to progress.

- States can convene and connect key stakeholders, such as behavioral health agencies, Medicaid programs, payers, provider groups and patient advocates to develop a roadmap toward full integration of behavioral health within health information exchange in their state. The state HIT Coordinator should help to coordinate this activity.

- States can charge convened groups to identify use cases that would benefit from additional automation or standardization, and develop priorities for key initiatives that support system efficiencies, clinical decision support and evidence based guidelines.

- States can use their purchasing power to specify that behavioral HIT be a requirement in provider networks and contracts for Medicaid managed care and state employee benefit programs.

- States can work with stakeholders to develop educational opportunities for providers and consumers to clarify the value of including behavioral health information in health information exchange and to improve understanding of the laws affecting behavioral health information.

  Inherent challenges and limitations may make progress in incorporating behavioral health care into state health information exchange efforts difficult, but careful planning, informed by other states' experiences and strategies, can increase the chance that tangible returns and system efficiencies are realized.

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