Using HIEs to Connect Behavioral and Physical Health
Now and the Future
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ConnectHealthcare (an HIO)
HIO vs HIE
Q1  HIE experience?
A Case Study

Electronic Health Record

Hospital Emergency Department

Large Scale Clinic System
Assessment, controversy and retreat

• Confidentiality switch in EHR is three screens deep: home/advanced/structure. Not always used.
• BH leadership does not trust that BH staff will always turn the switch.
• IT agrees to run a screening program nightly to identify any substance use patient with the confidential switch off.
• Clinic agrees to seek authorization for data release from all patients.
• BH leader says risk is still too great.
• Hospital leadership says data (including substance use data) is needed to provide proper patient care.
• Clinic compliance officer says clinic should not provide files.
This Talk
History

1995
Community Health Information Networks (CHINs). OCHIN.

2004
Regional Health Information Organizations (RHIOs). From President George W. Bush’s Health Information Technology Plan” CalRHIO.

2009
Health Information Exchanges (HIEs) and HIOs. American Recovery and Reinvestment Act of 2009.
Exemplars

Santa Barbara County Care Data Exchange, 1998
• Dr. David Brailer / $10 million from CHCF
• Closed in December 2006, several months after operations began.
• Providers had not realized benefit.
• No ongoing financial support.

CalRHIO, 2005
• Dr. Molly Coye, $10 budget over 5 years.
• Some work in Orange County.
• In five years, unable to find a way forward.
• CalRHIO and CAeHC were competitors to be the ARRA-designated agency but unable to reach agreement.
Exemplars - 2

Cal INDEX, 2014

• David Watson with $80 million in funding from Blue Shield of California and Anthem Blue Cross
• Did not gain traction.
• In early 2017, Cal INDEX merged with Inland Empire HIE to form Manifest MedEx, also with significant funding.
Types of HIE

Community HIE

Enterprise HIE
Federated vs Repository

At query location

At provider locations

At repository location

Provider locations
CA: urban dense / rural sparse

Red = 3k+ pop’n / sq. mile

Yellow = rural (Economic Research Svc)
# HIOs/HIEs in CA

<table>
<thead>
<tr>
<th>Central Coast Health Connect</th>
<th>OCPRHIO (Orange Co.)</th>
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<tbody>
<tr>
<td>Central Valley HIE</td>
<td>RAIN Live Oak HIE</td>
</tr>
<tr>
<td>ConnectHealthcare</td>
<td>Redwood MedNet</td>
</tr>
<tr>
<td>Cottage Community HIE</td>
<td>San Diego Health Connect</td>
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<tr>
<td>Lanes (LA)</td>
<td>Santa Cruz HIO</td>
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<tr>
<td>Manifest MedEx</td>
<td>San Joaquin Community HIE</td>
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<tr>
<td>Marin Health Gateway</td>
<td>SacValley MedShare</td>
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<tr>
<td>NCHIIN (Humboldt)</td>
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Nationally

58 regional HIEs

Many enterprise HIEs
# Variations in data exchange

<table>
<thead>
<tr>
<th>Mode</th>
<th>Provenance</th>
<th>Strategy</th>
<th>Connections</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td>eHealth Exchange</td>
<td>ONC</td>
<td>Point-to-point</td>
<td>HIEs, agencies, providers</td>
<td>Clumsy, limited use</td>
</tr>
<tr>
<td>Carequality</td>
<td>Some EHR vendors</td>
<td>Web of links</td>
<td>EHR-to-EHR</td>
<td>90% acute</td>
</tr>
<tr>
<td>Commonwell</td>
<td>Cerner + other EHRs</td>
<td>Web of links</td>
<td>EHR-to-EHR</td>
<td>60% ambulatory</td>
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<tr>
<td>Epic Care Everywhere</td>
<td>Epic EHR (medical centers)</td>
<td>Connect Epic instances</td>
<td>Epic-to-Epic</td>
<td>Epi-to-Epic + Carequality</td>
</tr>
<tr>
<td>Regional HIEs</td>
<td>ARRA HITECH funding</td>
<td>Regional</td>
<td>Providers, others</td>
<td>Growing but white space</td>
</tr>
<tr>
<td>Patient Centered Data Home</td>
<td>National assn of HIEs (SHIEC)</td>
<td>Link HIEs based on pt home zip</td>
<td>Regional to national</td>
<td>Growing but not yet soup</td>
</tr>
<tr>
<td>Emergency Dept Info Exchange</td>
<td>Vendor’s idea</td>
<td>National ED data repository</td>
<td>National repository</td>
<td>State-by-state growth</td>
</tr>
</tbody>
</table>
Patient Centered Data Home

20 HIEs
Q2. Familiar with these HIE methods?
Trust frameworks

- Agreement
- Certificates

Examples
- Direct Trust (person-to-person)
- eHealth Exchange, Carequality, Commonwell (DURSA)
- Epic (Epic agreement)
- CTEN (CalDURSA)
- TEFCA (new from ONC)
Sustainability

Publicly supported
• ARRA grants for many in 2013
• Some state HIEs
• Grants to supplement

Member supported
• Subscriptions
• Product fees
• Volume-based fees

Payer supported
• Payer quality bonus
  • Data contribution
  • Threshold
• Reimbursement tiers based on HIE participation
Barriers to participation in HIE
Future of HIE & Interoperability?

No question about interoperability

Unclear how different models will relate and which will thrive
Behavioral Health
Q3. Audience

Mental health treatment
Substance use treatment
Legal
Compliance
Management
Other
All discussion is about *treatment*!

Not payment or health care operations.
Mental Health Information: HIPAA

• No transmission of professional notes
• Mental health information can move as physical health information (under HIPAA)
Mental Health Information: California Law

State Health Information Guidance (SHIG)
Primary California Laws

• Confidentiality of Medical Information Act (CMIA) CA Civil Code §56 et seq.
• CA Welfare and Institutions Code (WIC). Various including Lanterman-Petris-Short Act at §5328 et seq. (LPS)
• CA Health and Safety Code (HSC) including §11845.5, 123110 and 123125.
• CA Code of Regulations Title 9 – Rehabilitation and Developmental Services including §10568(c).
Lanterman Petris Short Act

• Passed in 1967, 29 years before HIPAA envisioned electronic exchange of health information

• The Act applies to patients who are voluntarily or involuntarily treated in an institutional (nonprivate) setting.

• The Act ended hospital commitment by the judiciary system, except for criminal sentencing such as for sexual offenders and the gravely disabled.
Can a mental health provider share information with a physical health provider?

Yes

No

LPS Act?

Can share

Get pt auth

Yes

No

Does physical health provider have medical or psychological responsibility for patient?

Source: Scenario 1, SHIG, pp. 42-46.
Can a physical health provider share information with a mental health provider?

Source: Scenario 2, SHIG, pp. 47-51.
Substance Use
Can a substance use provider share information with another substance use provider?

Provider not subject to 42 CFR Part 2  [(1) federally funded & (2) hold self out as SU provider]
• General health information necessary for diagnosis and tr may be shared

Subject to 42 CFR Part 2
Does Provider belong to the Part 2 program or a QSO?
• Yes.  Information can be shared.
• No.  Patient authorization is required to share patient information.

Source:  Scenario 3, SHIG, pp. 52-55.
Qualified Service Organization Agmt

- A qualified service organization (QSO) provides administrative, professional or clinical services to a Part 2 program under a written agreement indicating that the organization is bound by the regulations applying to the Part 2 program and that it will legally resist any attempt to obtain unauthorized access to the patient records. [This is parallel to a Business Associate Agreement.] A QSO cannot provide general medical services (e.g., primary care).
Q4. Any of you involved with QSOAs?
HIO Information Sharing
Mental health data & HIE

California Law & HIPAA
Can a mental health provider share and store MH information in an HIO?

Source: Scenario 20, SHIG, pp. 132-134.
Business Associate Agreement

A Business Associate Agreement is between a covered entity and a contractor (business associate) for the purpose of maintaining the security of protected health information and HIPAA compliance.
May an HIO participant entity access mental health information from the HIO?

Does HIO data recipient have medical or psychological responsibility for the patient?
• Yes. May access patient data.
Does the HIO data recipient have a BAA with the original data provider?
• Yes. May access patient data.
Is the information necessary for the recipient to file a claim?
• Yes. May access patient data.
Is the data needed to respond to a medical emergency?
• Yes. May access patient data.
No to all.
• Authorization is required.
Source: Scenario 22, SHIG, pp. 141-145.
Substance use & HIE

SAMHSA 42 CFR Part 2
Can a substance use provider store data on an HIO?

Source: Scenario 19, SHIG, pp. 128-131.

- QSOA
- Consent
What substance use information can a provider store on an HIO?

Without authorization, a SU program can disclose to an HIO:

- Patient demographics
- Diagnosis
- Prognosis
- Treatment information for use by treatment/prevention professionals

- In the same facility or program
- In the same qualified service organization (QSO)

With authorization

Source: Scenario 20, SHIG, pp. 128-131.
Can an HIE participant access substance use patient information from an HIE?

Is HIO data recipient employed by QSO for the patient’s substance use program?

- Yes. Recipient may access patient SU information.

Other rare situations...

If No to all above, authorization is required.

Source: Scenario 21, SHIG, pp. 135-140.
Consent options

To Whom:
1. Name of an individual
2. Name of an entity w treating provider relationship w patient
3. Name of an entity not a treating provider such as an HIE plus
   1. Name of a participants
   2. Name of an entity
   3. General designation, e.g., “all my treating providers”

HIE must track the list of disclosures to whom made.
Disclosure to whom?

Q: Can an HIO use a consent form that allows disclosure to “HIO members”?

A: No. 42 CFR Part 2 §2.31(a)(2) states that consent forms must include the name of individuals or organizations who will receive the Part 2 data. Such a consent should identify the organizations by a list or attachments.
Amount & kind of information to disclose

- “All of my substance use disorder records”
- Not “all of my records”
Consent Duration & Purpose

Q: Can a consent state that disclosure is good until consent is revoked by the patient?
A: No. Can be “upon my death.”

Q: Is “treatment” a sufficient description of the intended purpose of a disclosure?
A: Yes. But the data would then not be usable for disease management, QI, payment, etc.
Redisclosure

Q: Must a Part 2 program notify the HIO that it may not redisclose data without patient consent?
A: Each disclosure with written patient consent must include a notice that the data may not be further disclosed without written consent. A specified paragraph must be used.

Q: Can a single consent form be used for the disclosure to the HIO and for redisclosure to other identified parties such as HIO members?
A: Yes, if the purposes of the disclosures are the same. The redisclosure paragraph is required for each subsequent redisclosure.
Actual BH HIOs in CA & Beyond
HIO participants decide
• How to submit data as physical health or behavioral health and
• What to submit

Data retained in separate databases

→

Behavioral health participants have access to both systems
Santa Cruz County Behavioral Health Division
• Bringing up Netsmart connection to HIE

In both systems
San Joaquin Community HIO

Participants
• County hospital
• County BH program

Data coded by program
• BH data provided to HIO but only available
  • Within the county BH organization
  • In emergency by “break the glass”
• First County BH department in CA to contribute data to a community HIE
SJ Behavioral Health Approach

• Limited Mental Health data set shared
  – Demographics, diagnoses, medications, allergies, and lab results
  – No substance use information (42.CFR.2) or psychotherapy notes
  – Data filtered on way out of EHR & further segmented in HIE

• Opt-in, whereas rest of HIE is opt-out
  – 97% opt-in rate to date
  – Consent status captured via electronic signature, transmitted from EHR to HIE
Consent2Share

• An open-source software application

• Allows patients to specify online what BH health information they would like to share with primary care and specialty physicians
Data segmentation and consent

- Elicit client consent
- Segment clinical data
- Comply with client choices
- Comply with 42 CFR P2
Considerations

- Need for highly skilled staff
- New policies, procedures, workflows
- New processes
- Patient and staff education
- Patient access to computers, tablets, etc. to enter preferences
- Implementation plan for an HIE: 1 year, about $600k
Consent2Share Implementation Tools

For Staff, Counselors and Physicians

- Waiting room video
- Flyers for Offices and Group Rooms
- Client Brochures
- FAQs
- Client instructions for completing Consent2Share Policy
- Consent2Share Website

For Clients

- Patient Journey Map
- Staff workflows for Counselors and Front Desk
- Staff roles and responsibilities
- Staff instructions for creating client accounts
- Scripts and talking points for staff and providers
- Training and Consent2Share demo
- Consent2Share Website overview
• Prior to C2S
  • Poor communication between Behavioral Health and Primary Care
  • Fragmented care coordination
  • Less than optimal health outcomes

• After C2S
  • Patient wishes in C2S mediate the data exchanged
Future of Behavioral & Physical Health and HIE
First cause of death under 50

- Hydrocodone
- Hydromorphone
- Oxycodone
- Oxymorphone
It is dangerous to treat a patient without knowing:

- Problem list
- Medications
- Lab results
- Allergies
A few well-known MH & SU sufferers

<table>
<thead>
<tr>
<th>Buzz Aldrin</th>
<th>Jon Hamm</th>
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<tbody>
<tr>
<td>Betty Ford</td>
<td>Kristen Bell</td>
</tr>
<tr>
<td>Drew Barrymore</td>
<td>Robin Williams</td>
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<tr>
<td>Brad Pitt</td>
<td>Sir Elton John</td>
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<tr>
<td>Tipper Gore</td>
<td>Abraham Lincoln</td>
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<tr>
<td>Prince Harry</td>
<td>Benjamin Disraeli</td>
</tr>
<tr>
<td>Frank Lloyd Wright</td>
<td>Charles Schwab</td>
</tr>
<tr>
<td>George Washington</td>
<td>Leonard Bernstein</td>
</tr>
<tr>
<td>Ted Turner</td>
<td>Winston Churchill</td>
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Changing mores, regulation & technology

- Lucia Savage, former Chief Privacy Officer, ONC
  - “Important to keep rules simple in harmony with HIPAA.”
- Occasional bills to simplify SAMHSA approach.
- Trade off between number of people who die because information not present and protecting reputations of SUs.
- Better to outlaw discrimination than data sharing.
Prediction --
If data exchange is allowed under HIPAA and other laws, and the quality of the patient’s care depends on access to that data, there is a moral imperative to share it.

Patient well-being should trump perceived risk of disclosure or misinterpretation of privacy laws.

-- Robert Moore, MD, MPH, MBA
Within 5 years --

All patient data will be completely integrated and available for the treating provider.

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