• About ONC and the Office of the Chief Privacy Officer
• Statement of the Problem
• HIPAA and Coordinated Care for Individuals Who have a Mental Illness
  » HIPAA Permitted Uses
  » Special Mental Health Privacy Laws
• How is ONC supporting the needs of the Mentally Ill and their physicians and therapists?
  » Advanced Model HIE grants
  » State Medicaid Directors Letter
• OCPO Resources and Tools
• Questions?
Provides analysis and education in response to privacy and security needs generated as a result of the evolution of the digital health information ecosystem. Advises the National Coordinator, other HHS agencies, other branches of government, and states.
Ongoing Concerns in Behavioral Health

• A Mom in recovery had her 2-month old infant removed from her custody after a hospital reported that she had legally prescribed methadone in her system.

• A young man in recovery was refused work reinstatement despite successful treatment for alcoholism and his physician’s clearance.
The High Cost of Mental and Behavioral Health Care*

- On average, care for patients with Behavioral Health illness cost $450 more per month than patients without mental illness (1)

- GAO has documented the high cost of mental illness for States (2):
  - Less than 15% of all Medicaid-only enrollees have Behavioral Health conditions but account for half of “high expenditure” enrollees each year.
  - 71% of high-expenditure Medicaid-only enrollees with a substance-abuse condition also had one or more Behavioral Health conditions.

- Numerous studies document the cost benefits of integrating primary care and behavioral health
  - Study of 551 patients receiving integrated care showed lower costs of $3,363 per patient over a four year periods (3)
  - Intermountain Healthcare program integrating care saved $667 per patient in the first 12 months (4)
  - Group Health Cooperative’s coordinated care of patients with diabetes and major depression reduced 5-year costs by $3,900 per patient (5)

*See References
The Impact on Veterans

- Large, mobile, dispersed, federally funded beneficiary populations:
  - DOD: 9.5 million
  - VHA: 8.3 million
  - In every state

- 52,022 wounded Service Members from Iraq and Afghanistan:
  - 9,502 are National Guard or Reserve

- 311,688 of the 1.8 million Veterans who deployed to Iraq or Afghanistan suffer from PTSD

- 22% of Veterans receive Behavioral Health care outside the VA system

* Source: https://scholarblogs.emory.edu/sick/2014/03/03/veteran-ptsd/, accessed on 2 DEC 15
Helping Despite Challenges

• Preventing Health Status Discrimination
• Giving patients confidence in their hospitals, physicians and therapists
• Using data appropriately to improve care
• Moving towards Better Health, Lower Cost, Healthier People?
HIPAA Supports Exchange of Behavioral Health Information for Coordinated Care

- **MYTH:** HIPAA makes it impossible to exchange health information electronically for patient care

- **FACT:** HIPAA permitted uses actually allow health information to be exchanged in a number of specific circumstances and does not require patient authorization. For example:
  - **Providers can share PHI for Treatment**, broadly defined to include things like referrals, care management by someone hired by the provider, or transitions of care. There are no carve outs for records related to mental or behavioral treatment except
    - Psychotherapy notes maintained separately from other health information.
  - **Providers and Payers can share PHI for Operations** such as quality improvement, care coordination and other activities
  - **Beware!** Other laws (e.g., state laws, or 42 C.F.R. part 2) or organizational policies that may impose such requirements, especially around sharing mental and behavioral health information.
HIPAA Permitted Uses Allow Exchange of MH and BH Information

- Patient's with Behavioral Health PHI
- Licensed Professional Counselor
- Exchange of Patient’s MH PHI
- Primary Care Provider
- Exchange of Patient’s MH PHI
- Physician’s Office
- Exchange of Patient’s MH PHI
- Behavioral Health Clinic

The Office of the National Coordinator for Health Information Technology
OCPO launched a 4-part blog series entitled the “Real HIPAA Supports Interoperability.”

» Blog 1: The Real HIPAA Supports Interoperability

» Blog 2: Background on HIPAA’s PU&D

» Blog 3: Examples of Care Coordination, Care Planning, Case Management

» Blog 4: Examples of Quality Assurance and Population-Based Activities

OCPO/OCR co-branded educational fact sheets that provide practical, plain language, examples with illustrations to supplement the blog series.

https://www.healthit.gov/newsroom/fact-sheets
Permitted Uses and Disclosures: Exchange for Health Care Operation [PDF - 1.3 MB] *
Permitted Uses and Disclosures: Exchange for Treatment [PDF - 1.1 MB] *
**D.C. Code § 7-1201.01 Definitions**


Behavioral Health information means any written, recorded or oral information acquired by a Behavioral Health professional in attending a client in a professional capacity which:

(A) Indicates the identity of a client; and

(B) Relates to the diagnosis or treatment of a client’s mental or emotional condition.

**N.C. Gen. Stat. § 122C-3 Definitions**


Confidential information means any information, whether recorded or not, relating to an individual served by a facility that was received in connection with the performance of any function of the facility. Confidential information does not include statistical information from reports and records or information regarding treatment or services which is shared for training, treatment, habilitation, or monitoring purposes that does not identify clients either directly or by reference to publicly known or available information.
NGA Project – Developing a State Interoperability Roadmap

Timeline and Objectives Sept 2015 to May 2017

Phase I
Learning & Dialogue
Thru Jan 2016

Phase II
Expert Roundtable
Apr 2016

Phase III
State Interoperability Roadmap
Jul 2016

Phase IV
Technical Assistance & Implementation
May 2017
ONC Direct Support to Health Information Exchanges and Communities

- Focused on expanding access to health information exchange across a variety of providers through a variety of grant programs

- Acknowledges the importance of efforts to integrate behavioral health information into health information exchange
ONC HIE Grant Activities that Impact Coordinated Care for Individuals with Behavioral Health Concerns.

• **Advance Interoperable Health Information Technology Services to Support Health Information Exchange (February 2015)**
  
  » 12 geographically dispersed awardees including clinical and non-clinical care providers across the entire care continuum identifying and implementing HIE technologies and supporting data exchange.
  
  » Target populations include MU eligible professionals and hospitals, long term post-acute care facilities, BH providers, social service providers, public health departments and researchers
  
  » *Leverage successes from initial State HIE projects to increase the adoption and use of interoperable health IT to improve care coordination.*

• **Community Interoperability and Health Information Exchange Cooperative Agreement Program (February, 2015)**

  » 10 geographically dispersed awardees creating projects at the community level to increase HIT adoption and use in support of information exchange for providers who are not eligible for MU incentives

  » *Create projects at the community level to increase HIE adoption and use among specific populations, which will help to address interoperability challenges.*
Case Study: Colorado

• Colorado Pilot to share behavioral health data through HIE with primary care providers

• In the news

  
The CMS Medicaid Data and Systems Group and ONC Office of Policy issued new guidance on how states may use HIE matching funds to connect behavioral and other providers to Medicaid Meaningful Users:

• This updated guidance will allow Medicaid HITECH funds to support all Medicaid providers with whom Eligible Providers want to coordinate care.

• Medicaid HITECH funds can now support HIE onboarding and systems for behavioral health providers, long term care providers, substance abuse treatment providers, home health providers, correctional health providers, social workers, and so on, when they connect to Eligible Providers.

• It may also support the HIE on-boarding of laboratory, pharmacy or public health providers.

• Reinforces that HIPAA supports the exchange of information between physical and Behavioral Health providers.
CMS Medicaid Innovation Accelerator Program (IAP)

• IAP is designed to build state capacity in support of ongoing delivery system reform and innovation efforts around Medicaid
• Includes Physical and Behavioral Health Integration Priority Area:
  • Customize for specific populations
  • Spread integration efforts to new areas of participating states
  • Expand inclusion of new types of health professionals
  • More info at: https://innovation.cms.gov/initiatives/MIAP/.
• ONC OCPO Supports IAP and other CMMI programs with technical assistance for grantees on issues of health information privacy and security.
  • Communities of practice; webinars, 1:1 assistance for states.
That was Policy. What about Technology & Standards?

- DS4P
- APIs
- PGHD
- Computable Privacy/Electronic Consent Management
- Consent-2-Share/Code Mapping
Data Segmentation for Privacy

• ONC three year project (the Data Segmentation for Privacy initiative) which developed and piloted standards to integrate behavioral health-related information into the primary care setting.

• Now included as voluntary Certified EHR Technology (CEHRT) for Meaningful Use Program Stage 3.

• Incorporated into the ONC Behavioral Health Roadmap (with SAMHSA input)

• Next Up: Consent2Share – open source tool for consent management and data segmentation
  » Integrates with electronic health records and health information exchange systems via interoperability standards.
  » Allows clients control over which health information they share, and with which providers.
  » Is compliant with privacy and confidentiality regulations, including 42 CFR Part 2.

• OCPO will explore opportunities with additional codes sets and clinical categories of data not currently in scope for consent-2-share

http://www.healthit.gov/providers-professionals/data-segmentation-and-you
How APIs and CEHRT Fit Into the Picture

• APIs can enable health information to be shared between systems and via third-party apps

• Can support exchange of information as allowed or required by HIPAA
  » For example, enable one provider’s system to request and obtain clinical test results from another provider’s system. More info available at healthit.gov.

• Can support patient electronic access to health information for purpose of HIPAA Access Rule
  » For example, enable patient to use a third-party app to access their PHI from provider’s system.
Patient Access under HIPAA Resources

- OCR Patient Access Guidance
  - [http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html](http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html)

- OCR Patient Access Blog Post
  - [http://www.hhs.gov/blog/2016/01/07/understanding-individuals-right-under-hipaa-access-their.html#](http://www.hhs.gov/blog/2016/01/07/understanding-individuals-right-under-hipaa-access-their.html#)

- ONC Patient Access Blog Post

ONC Resources and Tools

• Permitted Uses Fact Sheets
• Privacy and Security Guide
• Mobile Device Web Pages
• Data Segmentation Resources
• Behavioral Health and Health IT
• Opioid Crisis
April 2015 Updated Guide focuses on:

- Privacy and security requirements for EHR Certification Criteria - 2014 Edition
- Updated privacy and security requirements resulting from HIPAA modifications
- New, practical examples of the HIPAA Privacy and Security Rules in action

Developed in coordination with HHS Office for Civil Rights and Office of General Counsel

Mobile Device Materials Available Online

- Materials available on [HealthIT.gov/mobiledevices](http://HealthIT.gov/mobiledevices) include:
  - Fact sheets
  - Posters
  - Brochures
  - Postcard
  - Educational videos
References


(2) Government Accountability Office, Report 15-460, pp. 11-12

