Unlocking and Sharing Behavioral Health Records: Movement Emerges to Exchange Sensitive Records through HIEs

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Sharing behavioral health and physical health information is a growing concern for the US healthcare system. Sharing the history and status of patients' symptoms and progress-or lack of progress-between and among physical health and behavioral health providers is essential for assisting the two industry segments' mutual patients to receive comprehensive quality care.

A recent report from Johns Hopkins, titled "Separate may not be equal: A preliminary investigation of clinical correlates of electronic psychiatric record assessibility in medical centers," indicates that organizations that separate and do not make behavioral health documentation available to other providers have a higher incidence of patient readmissions to the hospital when compared to cases where behavioral health and physical health records are shared in the inpatient setting. It goes beyond just sharing the record. When records are shared, providers tend to communicate more with each other and at least move towards a "team approach" to patient care. When records are not shared, it is extremely difficult to have providers act and communicate as a team.

Typically, when records are not shared, providers do not go out of their way to communicate verbally with each other. They just don't communicate at all, as there is no culture supportive of team or care collaboration.

According to the Johns Hopkins report, published in the December 2012 *International Journal of Medical Informatics:*

> "recent initiatives like interoperable implementation of electronic health records (EHRs) and the development of Health Information Exchanges has made it possible for behavioral and physical health providers to exchange information. But the logistics of this type of data transfer goes well beyond mere technical logistics-though technical connection issues are involved as well. Privacy, security, policy, compliance, and other barriers have made the wide exchange of this type of sensitive information difficult. But there are initiatives underway that are challenging these barriers and working to actually share behavioral health information across HIEs."

Better Coordination, Better Healthcare

As the nation moves forward in its attempt to meet the triple aims of "better health, better care and lower costs," identified by former Centers for Medicare and Medicaid Services (CMS) head Dr. Don Berwick as a focal point for CMS initiatives, the focus should center on care coordination. Whether one is an eligible professional under the "meaningful use" EHR Incentive Program or not, providers must be positioned to share information electronically with other providers in their patients' healthcare system.

The industry is moving toward making it the patient's healthcare system, since each patient is different and has different needs depending on one's strengths and the level of illness they are dealing with. Many providers and healthcare professionals recognize the need for a Community Referral and Care Coordination Tool (CRCCT) that would allow sharing of information among all providers. This is not a new idea, but there is not yet a product available that will allow all providers to access a coordinated record and allow providers who don't have EHRs to include their input. Behavioral health providers involve a number of "wrap around" or "community support services" when they develop treatment plans for patients. While some organizations may never have a certified EHR, their input into the treatment plan allows all providers the ability to see how a patient is progressing in meeting goals. This is extremely important for coordinated care.

Behavioral health providers are currently excluded, for the most part, from the meaningful use program. Only physicians working in behavioral health organizations and nurse practitioners under Medicaid are eligible professionals under meaningful use. Many behavioral health providers recognize this as a shortfall of the program. Other segments of the healthcare industry were left out as well.

There are two bills, one in the Senate (S. 539) and one in the House (H.R. 6043) that would allow behavioral health providers such as licensed psychologists, licensed social workers, and some behavioral health organizations to qualify for meaningful use incentives. Many feel providing these incentives would allow behavioral health providers to be on an even playing field with their medical counterparts. The National Council for Behavioral Healthcare is leading the way in advocating Congress to change the program to include the behavioral health sector.

Technical Difficulties in Behavorial Exchange

Accountable care organizations (ACOs) and other shared savings models are based on the premise that these organizations will provide coordinated care and thus better quality care and reduced costs. Yet most ACOs do not include behavioral health providers. Behavioral health providers are a valuable asset for ACOs. Given the high percentage of patients with chronic diseases that have a co-morbid behavioral health disorder and higher costs, not coordinating care with behavioral health providers will prevent ACOs from fully realizing quality outcomes and reduced costs. Patients will end up in emergency rooms and in inpatient beds unnecessarily, which will dig deeply into any savings that might have been achieved. Many healthcare providers view a hospitalization or unnecessary emergency room visit as failed outpatient treatment and evidence of uncoordinated care.

Even the Beacon Communities, which were selected to receive federal funding to build and strengthen their health information technology infrastructure and focus on changing health outcomes and reducing costs in specific geographic areas across the country, do not all include behavioral health organizations.

The reason-it is hard to include behavioral health providers in information exchange initiatives due to some state-specific confidentiality and privacy laws for mental health and federal laws around sharing alcohol and substance abuse information known as 42 CFR Part 2.

Most state mental health laws follow HIPAA, but some are more stringent-42 CFR Part 2 is more stringent than HIPAA in several ways. Information cannot be shared for all treatment, payment, or operations as in HIPAA. The patient must actually identify the reason for sharing information, which may be for treatment only.

Since most health information exchanges (HIEs) across the country have been established and programmed to follow HIPAA, they do not have the programming language embedded to allow a patient to select the purpose of sharing information as being only for treatment or payment or operations, or any combination of these. There is also a requirement that the patient identify who specifically can have access to their information. This is the barrier that makes compliance most difficult.

In a pre-HIE environment this would mean that the patient would specifically identify by name, title, or organization the provider that is allowed to view his/her information on the consent form. HIEs that have been in operation for some time did not program their systems to accommodate these requirements, since it is difficult to develop and manage.

Report: Patients “Hurt” By Lack of Exchange

A recent report from Johns Hopkins stated that medical centers that elect to keep psychiatric files private and separate from the rest of a person’s medical record may be doing their patients a disservice.

In a survey of psychiatry departments at 18 of the top American hospitals as ranked by *U.S. News & World Report’s* “Best Hospitals” in 2007, a Johns Hopkins team learned that fewer than half of the hospitals had all inpatient psychiatric records in their electronic health record systems, and that fewer than 25 percent gave non-psychiatrists full access to those records.

The study said psychiatric patients were 40 percent less likely to be readmitted to the hospital within the first month after discharge in institutions that provided full access to those medical records. Adam I. Kaplin, MD, PhD, an assistant professor of psychiatry and behavioral sciences and neurology at the Johns Hopkins University

School of Medicine, and leader of the study published online in the *International Journal of Medical Informatics,* said in a press release that "there are unintended consequences of trying to protect the medical records of psychiatric patients. When you protect psychiatric patients in this way, you're protecting them from getting better care.

"We're not helping anyone by not treating these diseases as we would other types of maladies. In fact, we're hurting our patients by not giving their medical doctors the full picture of their health."

EHR Revamp Necessary for Exchange

This difficulty goes beyond the HIEs; it starts at the EHR level. In order for a HIE to receive and process information correctly, the data that enters must be tagged in a manner that the HIE can process. This tagging of "metadata" would identify if the data is confidential or not, identify effective and expiration dates for the data to be shared, and identify which providers can have access and which cannot, as well as other specific parameters.

There have been no standards established for this metadata yet, but it is being worked on-most recently by the Office of the National Coordinator for Health IT's (ONC) Standards and Interoperability (S&I) Framework Data Segmentation for Privacy Workgroup (DS4P). This workgroup developed an implementation guide for vendors to identify how the data could be tagged and then processed. Without the data being tagged at the EHR level, it is nearly impossible for the HIE to receive the data and make the decisions on what can and cannot be shared on its own.

It is important to note that this tagging is not only required for behavioral health patients. It is just that 42 CFR is a big challenge, due in part to the previously identified programming issues, and resolving that involves the use case for other similar confidentiality requirements.

The Department of Veterans Affairs has Article 38, which regulates the sharing of patient information (including education, training, treatment, rehabilitation, or research) relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia. Many states have specific HIV/AIDS confidentiality laws, and patients have begun to request control of their data as it moves from provider to provider, hoping to restrict who sees what. For example, a patient may not want their podiatrist to see their behavioral health information or a specific lab result on a specific date.

Some feel that if data is restricted by a patient, and it is sent along with accessible information, the receiving provider must receive a message that this data is available but is restricted from being shared. This way the provider who has accessed the patient's record can request a release from the patient at the point of care or at least proceed to ask the patient more in-depth questions about their health to ensure a complete picture of medical circumstances is obtained.

Initiative Tests Behavioral Health Record Sharing

Hoping to foster better behavioral and physical health integration, the Center for Integrated Health Solutions (CIHS) was formed. This is a Substance Abuse and Mental Health Services Administration and Health Resource Services Administration cooperative agreement with the National Council for Behavioral Healthcare. A component of this cooperative agreement was to bring together the state HIEs or the state-designated entity for information exchange in five states to work on implementing the policies, procedures, standards, and protocols to actually share behavioral health and physical health data in a HIE environment.

CIHS provided one-year awards to Illinois, Kentucky, Maine, Oklahoma, and Rhode Island for the project. One of the artifacts of this effort was the development of a national consent template that meets 42 CFR Part 2 requirements and is computable in a HIE environment. To inform the effort, each of the states engaged providers in their area in independent behavioral health workgroups, as well as consumers in independent focus groups. Legal counsel from all five states were also involved.

One barrier in exchanging behavioral health information through a HIE that was not fully resolved by this effort was the "To Whom" section requirement of 42 CFR Part 2. As identified previously, 42 CFR Part 2 requires that the patient know and identify who they are allowing to have access to their records. Due to the way most HIEs are structured and programmed, a

HIE is not able to restrict providers who come into the HIE after the date a patient signed the consent from being able to view the Part 2 information.

The patient could see a list of all providers in the HIE as of the date they sign and opt out or not join the HIE if there were providers they did not want to have access to their record. But patients would not know specifically which providers joined after that date. Therefore, some feel the patient would not have the control called for in the 42 CFR Part 2 requirements. For the HIEs to implement this capability, the estimated cost ranges from $500,000 to $750,000 per HIE.

The consumer focus groups aimed to uncover what patients really want when it comes to this requirement. Conducted by the five state HIEs, consumers consistently identified that they were fine with not knowing which providers joined the HIE after the date they signed their consent. What was important to consumers was that only providers “involved in my care” would have access to their information.

All five of the participant HIEs do have the capability to work with this language, as they all require the provider to attest to having a treating relationship with a patient when they access their HIEs. Providers have to do this for accessing medical patient data as well. If this wording was “approved,” accepted, and utilized by all HIEs across the country, experts believe they would be better able to share behavioral health and physical health information.

The consumer would also be in full control of their record, since consumers know who is involved in their care and could opt out of the HIE at any time if there was a provider they were seeing and they did not want that provider to have access to their information.

Federal Groups Working on Exchange Solution

There are other efforts moving forward to help the exchange of behavioral health and physical health information. ONC has supported an effort under its State Health Policy Consortium Project, working with a number of states in sharing behavorial and other sensitive information using the federally developed Direct Secure Messaging Protocols, and also sharing across state lines.

Though work still needs to be done, many believe these initiatives will resolve behavioral HIE exchange barriers shortly. The proposal to accept a more open interpretation of the “To Whom” requirement under 42 CFR, which would allow information to be exchanged but still provide the patient/consumer/client complete control of their record, is one option. The Department of Health and Human Services’ Office of General Counsel would need to make a legal decision on this.

The use of Direct Secure Messaging is another easy method being considered by HIEs and providers to share behavioral health and physical health information. Behavioral health providers, whether they have an EHR or not, are being encouraged by exchange advocates to acquire a Direct Secure Messaging address to better enable health information exchange. This will allow them to share information to coordinate care with their medical partners and improve the quality of care they provide to the patients they serve.

Treat the “Whole Person”

Care coordination across all providers involved in a patient’s care should be the norm, a goal of all healthcare providers, and an expectation of all healthcare consumers. Increased communication between behavioral health and physical health providers will reduce the stigma associated with behavioral health illnesses.

Many feel the industry must work toward this goal and recognize that it is imperative to treat the “whole person” in a coordinated manner.

Reference

Kaplin, Adam et al. “Separate may not be equal: a preliminary investigation of clinical correlates of electronic psychiatric record assessibility in academic medical centers.” *International Journal of Medical Informatics*. December 20, 2012. http://www.ijmijournal.com/article/S1386-5056(12)00219-5/references.

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