Strategic Initiative #6: Health Information Technology, Electronic Health Records and Behavioral Health

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Issue Statement

"Electronic health records will provide major technological innovation to our current health care system by allowing doctors to work together to make sure patients get the right care at the right time and want to be clear that in all our Health IT investments, patient privacy is our top priority.[9]"

"Health information technology has great potential for improving outcomes while reducing costs and empowering consumers. For electronic health records to be comprehensive, they must incorporate data related to all key components of health. Behavioral health information should be included in the process of creating secure, consumer-centered information technology systems.[10]"

Health Information Technology (HIT) provides the overall framework to describe the comprehensive management and secure exchange of health information among providers, insurers, governments, including Tribes, consumers and other entities. It also provides the matrix out of which the electronic health record (EHR) evolves.

Throughout the continuum of health care, there is a need for an integrated system where general practitioners are supported by various specialty areas. Specialty fields, such as pediatrics, cardiology, oncology, orthopedics, and behavioral health (mental health and/or substance use disorder services) need to be able to share critical information with primary care practitioners.

The use of HIT has the potential to improve health care quality, prevent medical errors, increase administrative efficiencies, decrease paperwork, and improve patient health. EHRs that link across clinical practice areas, transfer information seamlessly and improve patient care by providing complete, accurate, and searchable health information at the point of diagnosis and care.

HIT, in general, and EHRs specifically, will allow behavioral health practitioners to engage their clients without having to wait for the exchange of records or paperwork, and without requiring unnecessary or repetitive tests or procedures. Because other medical and social consequences occur simultaneously with behavioral health

[9] Secretary Sebelius - http://www.whitehouse.gov/blog/2010/02/12/going-beyond-paper-and-pencil-investments-health-it

[10] Hogg Foundation

symptoms, having access to a patient's medical history, medication history, and other information is essential to identifying potential drug-drug interactions or other potentially harmful responses to a course of treatment. By facilitating the flow of critical clinical information, improved workflow efficiency and patient monitoring becomes achievable.

The SAMHSA HIT initiative operates under the umbrella of the Office of the National Coordinator for Health (ONC) and is coordinating many different activities into a coherent HIT strategy. The goal is to ensure the behavioral health provider network participates with the general health care delivery system in the adoption of health information technology, including electronic health records. SAMHSA is providing leadership to the behavioral health community and will align HIT activities in order to participate in health care reform and the integration of behavioral and primary health care.

The necessary infrastructure and expertise to support the effective use of health information technology is lacking in nearly every community in the United States, and particularly among behavioral health providers. These deficits are likely to be more severe for Tribal communities, so special attention should be paid to ensure that these needs are met. In addition, past issues with the use of data in Tribal communities' mean that special sensitivity is needed around the protection and use of data housed in the HIT systems used by Tribes. SAMHSA is engaged in ONC-sponsored activities that include collaborating with the Indian Health Service (IHS) to ensure our HIT activities include Tribal requirements. SAMHSA will continue to collaborate with IHS and to reach out through consultation with Tribes and Tribal organizations to make sure national behavioral health HIT efforts support their special requirements.

The primary role of SAMHSA's HIT effort is to support the behavioral health aspects of the EHR based on the standards and systems promoted by ONC. EHR content must be standardized (created in a standard format with standard terminology) so that it can be readily shared among providers. Standardized data are also required to facilitate the creation of clinical decision support. To facilitate the SAMHSA modern addictions and mental health service system, the HIT initiative is working with State and Territorial partners and emphasizing the importance of creating a holistic HIT strategy that includes comprehensive recovery-oriented programs.

It is imperative that required program reporting and quality measures become based upon the clinical information managed by the providers' EHR as well as their administrative systems.

Background

Starting in 2001, in partnership with States, Territories, and counties, SAMHSA began investing in EHR systems. Starting in 2004, SAMHSA has collaborated with many other Federal agencies around the development of HIT and EHRs. SAMHSA is currently participating with the HHS Office of the National Coordinator (ONC) for HIT, Department of Veterans Affairs, Indian Health Service, Centers for Medicare and Medicaid Services, and Department of Defense on several HIT initiatives. These initiatives include the development of EHR standards for behavioral health, the integration of security and privacy protection, and the ONC-Federal Health Architecture (FHA) Federal Health Information Modeling and Standards (FHIMS) initiative to integrate HIT data models across all Federal agencies.

Electronic Behavioral Health Records

To stay in business, safety-net behavioral health agencies (providers who deliver behavioral health care services for uninsured, Medicaid, and other vulnerable populations) must automate clinical records. To help them, SAMHSA recently re-joined the open source EHR collaboration, with a new $3.2 million per year, 5-year contract, starting in FY 2009 (open source refers to software that can be used and redistributed free of charge). SAMHSA is using this project to incorporate behavioral health clinical data standards so that States, Territories, and other government jurisdictions have viable EHR options to offer providers who treat safety-net populations. Open source software reduces the start-up costs to State and Territorial authorities and providers. Technical assistance for adaptation and adoption become the principal cost centers for using open source software.

From 2000-2004, SAMHSA invested $5.5 million in collaboration with leading State, Territorial, and county behavioral health agencies to create an open source, substance abuse treatment EHR. States and county agencies invested an additional $10M. During 2009, about 20 jurisdictions hosted this EHR.

EHR Standards & Guidelines

Starting in 2004, SAMHSA staff worked on the collaborative development of behavioral health EHR standards which included activities targeted at privacy protection.

Starting in 2005, SAMHSA staff worked on the collaborative development of behavioral health EHR standards which included activities targeted at privacy protection through HL7, the premier medical informatics standards development body and the ONC sponsored Health Information Technology Standards Panel.

Starting in 2006 and culminating in 2008, SAMHSA initiated and sponsored the development of an American National Standards Institute (ANSI) recognized Behavioral Health Electronic Health Record Functional Model.

In 2009, SAMHSA developed an EHRs Acquisition Guide for State and Territorial behavioral health agencies.

State and Territorial Data Interoperability

Starting in 2008, SAMHSA has collaborated with CMS to develop behavioral health components within the Medicaid Information Technology Architecture (MITA) initiative. SAMHSA developed a guide to assist mental health and substance use agencies in obtaining assistance through CMS for information technology initiatives to integrate mental health, substance use, and Medicaid data systems.

SAMHSA is completing a study of State mental health, substance use, and Medicaid data systems to determine their conformity with Federal data standards and assess their ability to create interoperable data systems and meet EHR data requirements.

SAMHSA is supporting meetings of representatives from the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and the National Association of State Medicaid Directors (NASMD) to discuss common issues in State and Territorial data interoperability and EHR adoption.

SAMHSA is working on a collaborative project with ONC to leverage their expertise in quickly developing and piloting behavioral health data standards to present to stakeholders and utilize in provider training, technical assistance efforts and information dissemination presentations.

Privacy and Confidentiality

On April 15, 2010, SAMHSA held an open meeting to discuss the implications of privacy and confidentiality in the evolving EHR framework. Representatives from ONC and CMS presented on the critical issues of privacy and confidentiality. Another meeting was held on August 4, 2010 to discuss Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE).

SAMHSA is participating in Standards Development Organizations such as HL7 including co-chairing security and privacy standards development.

SAMHSA is engaged with ONC to facilitate the incorporation of privacy and confidentiality regulations into EHR systems across the continuum of care.

Fast Facts

- Twenty percent of 175 substance abuse treatment programs surveyed had no information systems, e-mail or even voice mail.[62]
- On average, IT spending in behavioral health care/human services organizations represents 1.8 percent of total operating budgets—compared with 3.5 percent of the total operating budgets for general health care services. [63]
- Fewer than half of behavioral health and human services providers possess fully implemented clinical electronic record systems.[64]
- State and Territorial laws vary on the extent that providers can share medically sensitive information such as HIV status, treatment for psychiatric conditions or rules on sharing medical data.
- A study of 56 mental health clinicians in an academic medical center revealed that their concerns regarding privacy and data security were significant, and may contribute to the reluctance to adopt electronic records. [65]

Strategic Initiative 6 – Goals

Goal 6.1: Foster provider adoption and implementation of EHR.
Goal 6.2: Promote behavioral health EHR standards.
Goal 6.3: Address issues of behavioral health privacy/confidentiality in EHR.
Goal 6.4: Engage State and Territorial HIT leaders in creating and disseminating behavioral health functionality within provider EHR systems.

Goal 6.1: *Foster provider adoption and implementation of EHR.*

Objective 6.1.1: Use national forums to disseminate HIT strategies to State and Territorial behavioral health authorities, providers, consumers, families and other stakeholder groups.

Action Steps:

1. Prepare presentations to engage State and Territorial behavioral health staff participation in State and Territorial HIT and Health Information Exchange efforts.
2. Work with States, Territories, and providers that are developing HIT programs for service recipients across safety-net systems to collect and share HIT strategies.

Objective 6.1.2: Coordinate HIT strategy across SAMHSA.

Action Steps:

1. Convene stakeholder meetings to participate in the development of the SAMHSA HIT Strategy.
2. Facilitate the adoption of EHR for States, Territories, and providers who are committed to implementing the Good and Modern behavioral health system described by SAMHSA in consultation with the field.
3. Prepare and distribute one white paper on using HIT to deliver Good and Modern services.

Objective 6.1.3: Enable the integration of modern addictions and mental health services electronic health information into primary care and related safety net services for coordinated treatment via health information exchange.

Action Steps:

1. Support the identification and promulgation of data and architectural standards, and minimum data sets for the integration of behavioral health/addictions services into certified EHR technology through collaboration with the Office of the National Coordinator for Health IT (ONC), the HIT Standards FACA Committee and other State, Territorial, and national stakeholders.

Objective 6.1.4: Create a sustainable network of providers and vendors to support SAMHSA programs.

Action Steps:

1. Distribute the ANSI Standard Behavioral Health Functional Model to States, territories, providers and vendors.
2. Distribute the SAMHSA Behavioral Health Medicaid Information Technology Architecture Framework to States, Territories, providers, and vendors.
3. Distribute SAMHSA's EHRs Acquisition Guide for State Behavioral Health Agencies and providers.
4. Organize and deliver one presentation to engage State and Territorial Chief Information Officers and State and Territorial behavioral health staff at the next SAMHSA State Substance Abuse Director's conference.

Goal 6.1 Measures:

Measures under development

Goal 6.2: *Promote behavioral health EHR standards.*

Objective 6.2.1: Develop data analysis modeling framework.

Action Steps:

1. Collaborate with SAMHSA's Priority Initiative Quality and Outcome Measures team to identify ways to improve coordination between EHR and performance management systems and use data across systems.
2. Analyze data across safety net service systems and outcome measures in State and Territorial administrative data sets.
3. Collaborate with the Center for Medicare and Medicaid Systems (CMS) to add behavioral health contributions to the Medicaid Information Technology Architecture framework.

Objective 6.2.2: Propose new behavioral health quality measures to standards bodies such as National Quality Forum (NQF) and CMS.

Action Steps:

1. Establish formal relationship with non-profit quality standards and measures organizations, (e.g., NQF and the National Committee for Quality Assurance (NCQA)), including focus on modeling tools that may be unique to behavioral health.
2. Work with other safety net behavioral health stakeholders to engage organizations like NQF & NCQA in the quality measure vetting process.
3. Collaborate with ONC to define and implement behavioral health data and interoperability standards for meaningful use.
4. Expand technical content analysis/standards development within various external, State, and Federal initiatives (including CMS).
5. Collaborate with the ONC e-record data standards initiative to support the inclusion of behavioral health data quality measures.
6. Contribute to the development of applicable Federal regulations to ensure that additional behavioral health measures are included in meaningful use quality measures.
7. Expand collaboration with behavioral health stakeholder groups around specification of core data exchange sets that promote interoperability.

8. Collaborate with CMS, ASPE, VHA, ARHQ, IHS and NQF to make sure behavioral health EHR quality measures are defined and electronic specifications are defined.
9. Engage a multi-center (CBHSQ, CSAT, and CMHS) effort to define meaningful use quality measures for 2013 and 2015 regulations to be promulgated by CMS and ONC.

Goal 6.2 Measures:

Measures under development

Goal 6.3: *Address issues of behavioral health privacy/confidentiality in EHR.*

Objective 6.3.1: Educate and train behavioral health constituent groups on the options for including 42 CFR part 2 protections and mental health privacy within the EHR and HIE environment.

Action Steps:

1. Work with behavioral health constituent groups to disseminate privacy and confidentiality information through their stakeholder and provider networks.
2. Organize and deliver one presentation to engage behavioral health constituent groups about privacy issues at the State Systems Development Program (SSDP) conference.

Objective 6.3.2: Address 42 CFR Part 2 protections and mental health confidentiality standards within the HIE environment.

Action Steps:

1. Prepare and deliver presentations to facilitate understanding related to privacy in general and 42 CFR Part 2 specifically including the need for patient confidentiality.
2. Work with the HHS/ONC Chief Privacy Officer to coordinate privacy and confidentiality policy, including 42 CFR Part 2 and collaboration around patient identity management.
3. Provide education and training for State and Territorial HIE stakeholders on how to accommodate patient consent and privacy regulations in the sharing of protected health information and patient confidentiality across the continuum of care.

4. Expand SAMHSA participation in ONC privacy standards development activities around interface between privacy protection policy expressed in HIT privacy and appropriate software language.
5. Collaborate with VA on development and testing of interoperable privacy consent directive and other privacy policy implementation.
6. Develop and disseminate model forms or electronic transaction examples to accommodate 42 CFR Part 2 consent requirements in EHRs.
7. Develop structured natural language templates standard for patients, providers, and jurisdictions to define their privacy protection policies as resources are available.
8. Ensure that Federal Health Information Modeling (FHIM) project adopts one security and privacy model that incorporates Part 2 functionality.

Goal 6.3 Measures:

Measures under development

Goal 6.4: *Engage State and Territorial HIT leaders in creating and disseminating behavioral health functionality within provider EHR systems.*

Objective 6.4.1: Promote collaboration among substance abuse, mental health and Medicaid agencies within States and Territories, focusing on HIT/EHRs.

Action Steps:

1. Sponsor meetings among interested States and Territories to discuss IT integration strategy.
2. Expand support for HL7(a private, not-for-profit- standard setting organization) and ONC/FHIM Security and privacy standards development.
3. Facilitate the adoption of EHR systems for States, Territories, and providers that are committed to implementing the SAMHSA Good and Modern addictions and mental health service system.

Objective 6.4.2 Participate in ONC, privacy standard setting organizations, and Medicaid Information Technology Architecture (MITA) software standards specification process.

Action Steps:

1. Re-start SAMHSA support for MITA development.
2. Expand monitoring and commenting on ONC HIT FACA recommendations for technology standards development and adoption.

3. Continue and expand collaboration around open source development and re-use with States, Territories, and sister Federal agencies (e.g. currently Minnesota, Oregon, National Cancer Institute (NCI), and VA).

Goal 6.4 Measures

Measures under development

[62] Deni Carise, Ph.D., 2005
[63] National Council on Community Behavioral Health, 2009
[64] Behavioral Health/Human Services Information Systems Survey, 2009
[65] Salomon RM, Blackford JU, Rosenbloom ST, et al. *J Am Med Inform Assoc*. 2010 Jan-Feb;17(1):54-60.