Sharing Information Across Physical and Behavioral Health: Debunking Myths, Developing Strategies

Thursday, August 6th, 2015
2:30 - 4:00pm ET

For audio, please listen through your speakers or call:
1-844-302-6774, conference ID # 86279518

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# Agenda

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<td>Karla Lopez, Legal Action Center</td>
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<td>Sharing Information Across Physical and Behavioral Health: Strategies from North Carolina and New York</td>
<td>Amelia Mahan, Community Care of North Carolina</td>
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SHARING INFORMATION ACROSS PHYSICAL & BEHAVIORAL HEALTH

Presented by Karla Lopez of Legal Action Center
Aug. 6, 2015
Background

- The confidentiality of health information is protected by a combination of federal and state law
- Federal laws protect:
  - All health info (HIPAA)
  - Substance use disorder info (42 CFR Part 2)
- State law varies, but often protects the following types of information:
  - Mental health
  - HIV/AIDS
  - Reproductive health

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Federal Laws

Two federal laws apply to behavioral health information:

- (1) HIPAA
  - Applies to most health care providers and insurers
  - Applies to all types of health information
  - Federal “floor” of confidentiality

- (2) 42 CFR Part 2
  - Applies to substance use disorder ("SUD") prevention/treatment providers
  - Applies to information that identifies someone as having SUD
  - Older and stricter than HIPAA
Federal Laws

HIPAA

- HIPAA allows health information to be disclosed without patient’s consent for:
  - Treatment (e.g., to other health care providers);
  - Payment (e.g., to health insurer); and
  - Health care operations (e.g., administration of health care provider’s business)

- Learn more about treatment, payment, and health care operations disclosures:
  
  http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html

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Federal Laws

HIPAA, cont’d….

- HIPAA does not, for the most part, treat behavioral health information differently from other health information.
- Psychotherapy notes are more protected, but defined narrowly.
- Learn more about sharing mental health info under HIPAA: [http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html)
Federal Laws

42 CFR Part 2

- Substance use disorders carry potential negative consequences that are unique within the health care system
  - Criminal
  - Employment
  - Child custody

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Federal Laws

42 CFR Part 2, cont’d....

- These negative consequences often deter people from seeking treatment for SUD

- To address this problem, in the 1970s Congress passed federal confidentiality law for alcohol & drug treatment & prevention records—known as 42 CFR Part 2

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42 CFR Part 2, cont’d….

- 42 CFR Part 2 is usually more protective of patient privacy than HIPAA
- Only applies to SUD treatment/prevention providers:
  - “federally funded”
  - Hold themselves out as providing, and do provide, alcohol or drug abuse diagnosis, treatment, referral to treatment or prevention
- Can apply to an individual or an organization
- Does not apply to general medical facilities (but can apply to a unit or individual in such a facility)
Federal Laws

42 CFR Part 2, cont’d….

- Whereas HIPAA allows disclosures of general health information without patient consent for treatment, payment, or health care operations,

- SUD information protected by 42 CFR Part 2 can be disclosed only in certain circumstances……
42 CFR Part 2

Permitted Disclosures

- Internal Communications
- No patient identifying information
- Proper Consent
- Qualified Service Organization/ Business Associate Agreement
- Medical Emergency
- Reporting suspected child abuse and neglect
- Crime on program premises or against program personnel
- Research/ Audit
- Court Order

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State Laws

Whereas federal laws (HIPAA and 42 CFR Part 2) apply to all 50 states, states may also pass their own confidentiality laws, and these vary around the country.

Why do states pass confidentiality laws of their own?
- Usually, to protect sensitive health information, like mental health, HIV/AIDS, and reproductive health.

What to do when multiple laws apply?
- Follow the most stringent (most privacy protective) law.

How to find out if your state has its own confidentiality law(s)?
- Work with your agency’s privacy officer.
- Your state attorney general’s office may also have resources.

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Confidentiality of health and behavioral health information is protected by 2 federal laws

- HIPAA applies to all types of health care information
- 42 CFR Part 2 applies to SUD information

States also have their own confidentiality laws, often including state laws governing the confidentiality of mental health information
How can behavioral health information be included in integrated care settings?

- Under HIPAA (all health information):
  - If for treatment, payment, or health care operations, no patient consent needed—can generally exchange freely

- Under 42 CFR Part 2 (SUD information):
  - Patient Consent
  - Qualified Service Organization Agreement (like a Business Associate Agreement under HIPAA)
  - Medical emergency exception
  - *Within the SUD program*: internal communications exception
  - **Note**: Prohibition on Redisclosure for first two

- Be sure to find out whether your state has any additional confidentiality laws

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Myths & Facts

- **Myth**: Behavioral health information cannot be included in electronic health information exchange (HIE)
- **Fact**: It can be included, as long as the HIE has policies & procedures in place that comply with confidentiality laws.
  - **HIPAA**: If only exchanging information for treatment, payment, and health care operations, no patient consent needed.
  - **42 CFR Part 2**: Include SUD information by getting patient consent or by setting up a Qualified Service Organization Agreement. Some things HIE should consider:
    - Prohibition on Redisclosure
    - Consent (e.g., expiration, revocation, “to whom”)
    - No access by law enforcement
  - **State laws**

- **Model**: Consent 2 Share
  - [http://wiki.siframework.org/SAMHSA+Consent2Share+Project](http://wiki.siframework.org/SAMHSA+Consent2Share+Project)

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Myths & Facts

- **Myth**: Patients’ SUD information cannot be exchanged between physical & behavioral health care providers
- **Fact**: Information can be exchanged, staying mindful of confidentiality laws.

- Physical health → SUD: No consent required by HIPAA if disclosure is for treatment purposes
- SUD → Physical health: 42 CFR Part 2 allows disclosure in various circumstances, such as:
  - Patient consents (in writing)
  - Qualified Service Organization Agreement in place
  - Medical emergency
- Mental health: check state laws

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Myths & Facts

- **Myth**: If we provide SBIRT services, we will have to comply with that burdensome SUD confidentiality law (42 CFR Part 2)

- **Fact**: SBIRT services are only covered by 42 CFR Part 2 when they are conducted by providers who are already covered by 42 CFR Part 2 (i.e., alcohol/drug treatment/prevention providers)

42 CFR Part 2: Upcoming Changes?

- Last summer, SAMHSA held a Listening Session about the possibility of making changes to 42 CFR Part 2.

- Additional guidance from SAMHSA on how to exchange & integrate SUD information is expected soon, possibly in the form of changes to the law.

- Read Legal Action Center’s comments on proposed changes to 42 CFR Part 2 here: http://lac.org/wp-content/uploads/2014/12/LAC_COMMENTS.pdf

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Learn More

- Legal Action Center’s SUD confidentiality resources: http://lac.org/resources/substance-use-resources/confidentiality-resources/
  - Webinars
  - SAMHSA FAQs
  - Sample forms


- Legal Action Center hotlines to answer questions about alcohol/drug confidentiality (42 CFR Part 2):
  - Free hotline for New York providers

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THANK YOU!

www.lac.org
SHARING INFORMATION ACROSS PHYSICAL AND BEHAVIORAL HEALTH: DEBUNKING MYTHS, DEVELOPING STRATEGIES – COMMUNITY CARE OF NORTH CAROLINA (CCNC)

August, 6, 2015

Amelia Mahan MSW, LCSW
Director, Behavioral Health Integration
CCNC
amahan@n3cn.org
CCNC as Medicaid Contractor

- Primary Care Case Management System (PCCM) for NC Medicaid
- The PCCM program is carried out chiefly through:
  - (a) the development and support of primary care medical homes;
  - (b) a data-driven, statewide care management program.
Primary Goals of CCNC

- Improved care of the enrolled Medicaid population while controlling costs
- A “medical home” for patients, emphasizing primary care
- Community networks capable of managing recipient care
- Local systems that improve management of chronic illness in both rural and urban settings
CCNC Footprint Statewide

- 6,000 primary care providers (medical homes)
- 90% of PCPs in NC

All 100 NC Counties

- 1.4 million Medicaid Patients
- 300,000 Aged, Blind, Disabled
- 150,000 Dually Eligible

14 Networks

- Build & support medical homes
- Provide care management
- Each networkaverages:
  - 1.4 Medical Directors
  - 42.8 Local Care Managers
  - 1.8 Pharmacists
  - 1.0 Psychiatrist
Behavioral Health Initiative and Community Care

- Added in 2010, with a focus on:
  - Treating the “whole patient”
  - Breaking down “Silos” of care
  - Improving health outcomes

*** Not meant to replace Specialty Behavioral Health
NC Medicaid Statistics of People with Mental Health (MH) conditions

- 20% of Medicaid eligibles are diagnosed with a Mental Health (MH) condition
- 80% of patients diagnosed with MH are enrolled in a CCNC medical home/primary care practice
- 52% of patients currently actively care managed by CCNC are diagnosed with a MH condition
- 75% of people with a MH condition have another chronic health condition (hypertension, diabetes)
- 35% of people with a MH condition have 3 or more chronic health conditions

*Excluding IDD or Autism only*
Two different, but related, populations that we serve:

- **Individuals with behavioral health needs that can be treated within primary care setting (i.e. mild to moderate depression, anxiety, etc.)**
  - Focus – patient engagement, self-management, screening as needed, supporting primary care

- **Individuals with Serious and Persistent Mental Illness (SPMI) that also have comorbid chronic physical health needs (i.e. schizophrenia and uncontrolled diabetes)**
  - Focus – communication between medical and behavioral health providers and systems
Successful Communication Strategies

- **Relationship building:**
  - Clarifying language and reasonable expectations – Primary Care and Behavioral Health Providers are different!
  - Creating opportunities to meet

- **Strong referral and feedback pathways:**
  - Anticipating need and proactively developing
  - Full integration is the ideal. Effective collaboration should be the norm.

- **Shared data and documentation**
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For BH Providers: Practical ways to work Primary Care

- Gain consent upon intake for release of information to Primary Care for all patients
  - Should be part of agency culture that coordination will happen as a part of better health

- Collaborate and share care as needed
  - Close referral loop, share diagnosis, treatment approach, prognosis, labs, medications, etc.

- Share your specialty strengths – market yourself

- Improve skillsets and assessment with prevalent physical health conditions
  - Diabetes, Chronic Pain, Hypertension, Diabetes/Depression groups, etc.
REFERRAL PROCESS FROM PRIMARY CARE (PCP) TO BEHAVIORAL HEALTH (BH)

PCP identifies a BH need

The nurse or identified referral specialist fills out a form with the reason for the referral INCLUDING what was communicated to the patient and if medication management or consultation is being requested.

Point Person will set up an apt with the patient and call PCP to notify that the patient has an apt.

Form is faxed to BH at: FAX NUMBER

Form is given to Point Person at PCP to fax to Point Person at BH

Note: if patient is coming to “Open Access” A BH scheduler will generate an appointment and document this for PCP.

After apt. Point person at BH will fax form to PCP: did patient show up? Send fax to: FAX NUMBER

Documentation to be shared:
- Initial assessment (CCA from BH and Medical summary from PCP)
- If a medication is changed (goes both ways)
- 30 days (update)
- 90 days
- Discharge Summary

Point Person at BH will be given this info. to fax to PCP

Note: determine when a patient will be sent back to PCP to follow for medications
Example: 1 – ADHD – PCP prescribes and follows
2 – Comorbid – client is stabilized for 3 months at BH and then PCP continues the medication regime
3 – Complex – antipsychotics – client remains under care of psychiatrist at BH

Identify who will place summaries in PCP's EHR when received via fax?

As a QI check: CCWNC recommends tracking this process on a spreadsheet and deducing

Contact Information:
Referral Forms:

- **Form #1** – Behavioral Health Request for Information – this form is for behavioral health providers who begin working with a new consumer or identify a potential medical need, and wish to make contact with the PCP.

- **Form #2** – Referral to Behavioral Health Services Section I – this form is for PCPs to make a direct referral to a behavioral health provider for an assessment and/or services.

- **Form #3** – Behavioral Health Feedback to Primary Care Section II – this form is to be used in conjunction with the 2nd form listed above. It is for behavioral health providers to complete and send back to the PCP after receiving a referral.

[https://www.communitycarenc.org/population-management/behavioral-health-page/referral-forms/](https://www.communitycarenc.org/population-management/behavioral-health-page/referral-forms/)
Behavioral Health Provider Partnership (BHPP) – History

- Pilot project began in Fall 2011 at the state level to explore possibilities of creating the first CCNC specialty network

- Goals:
  - Use of data to promote and enhance integrated physical and behavioral health care for Medicaid recipients
  - Create clinical pathways that improve patient care
  - Explore alternative payment methodologies to allow behavioral health and other specialty providers to move towards value-based care
Direct Access to Informatics

- **CCNC’s Provider Portal** – secure portal that allows access to care team summary, visit history, medications, labs, etc. on a patient by patient basis

- **Patient List Report** – report showing a list of all patients connected with the CABHA
  - Can be filtered by CABHA site

- **Current Hospital Visit Report** – based on real-time Admission, Discharge, and Transfer (ADT) information
  - Indicates priority indicators, outpatient follow-up recommendations

- **Narcotic Utilization Report** – shows opioid, benzo, and hypnotic fills in the past year
**Provider Portal**

*Welcome: Annette Dubard*

**Sections:**
- Care Team
- Medications
- Visit History
- Communications (1)
- Linked Sites

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<tr>
<td>Phone 1:</td>
<td>Phone 2:</td>
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- Months Medicaid-Eligible: 12
- Medicaid: Yes
- Medicare: No
- HealthChoice: No
- Other Insurance: No
- Program Code: MADC

**Care Alerts:** 5
- Recent Hospital Use: 9
- Inpatient Visits *: 6
- Hospital Observation Stays *: 0
- ED Visits *: 10
- Imaging *: 26
- Office Visits */Visits toward Limit: 14 / 8
- Outpatient Behavioral Health *: 1
- ST/PT/OT *: 0
- Lab Values *: 99
- DME Supplies *: 0
- Medication Fills / History: 25 / 99
- Pain Agreements: 0
- Advance Directives: 0
- Other Pt. Documents: 0
- Immunizations: 0

**Care Coordination**

**Resources:**
- **CCNC Network:** AccessCare
  - Phone: (877) 570-0001
  - Fax: (919) 468-8573
- **Primary Care Mgr.: Kimberly Glass**
  - Care Mgmt. Status: Medium
  - Last Contact: 11/27/2012
  - Phone: (336) 264-8945
  - Fax: 
- **Network Pharmacist:** Gretchen Tong
  - Phone: (919) 843-4423
  - Fax: (919) 843-6544
- **Mental Health Local Management Entity (LME): Alamance-Caswell LME**
  - Phone: (888) 543-1444
  - County: ALAMANCE
- **CABHA:** PSYCHOTHERAPEUTIC SERVICES INC
  - Address: 1159 HUFFMAN MILL ROAD
  - BURLINGTON, NC 272158862
  - County: ALAMANCE

*Based on 15 months of data.*

**Carolina Access PCP:** UNC Internal Medicine (UNC P&A)
- Phone: (919) 966-6989
- Fax: (919) 966-6627

**Carolina Access PCP Address:**
- 101 MANNING DR, CHAPEL HILL, NC 27514-4220
- PCP County: ORANGE
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<td>15</td>
<td>$10</td>
<td>ANALGESICS,...</td>
<td>SHAILI NIRAN ...</td>
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<td>30</td>
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<td>30</td>
<td>30</td>
<td>$2</td>
<td>PSYCHOSTIMUL ...</td>
<td>PHILIP H. LA ...</td>
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<td>$24</td>
<td>ANTICONVULSA ...</td>
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### Recent Hospital Use - 9

This section displays visits within the past 90 days, updated twice daily from participating hospitals. Click here for list of participating hospitals. Visit information may be duplicated in the ED Visits and Inpatient Visit sections, which are generated after claims payment.

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>Admit Date</th>
<th>Discharge Date</th>
<th>Diagnosis 1</th>
<th>Diagnosis 2</th>
<th>Facility</th>
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<tr>
<td>Inpatient</td>
<td>11/26/2012</td>
<td>11/27/2012</td>
<td>ABD AND BACK PAIN FEVER N V</td>
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<td>ED</td>
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<td>11/26/2012</td>
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<td>11/9/2012</td>
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<td>AC RESP FAIL TRAUM/SURG</td>
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<td>11/6/2012</td>
<td>11/6/2012</td>
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<td>AC RESP FAIL TRAUM/SURG</td>
<td>University of North Carolina Hospital - Chapel Hill</td>
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### Inpatient Visits - 6

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<th>Diagnosis 2</th>
<th>Diagnosis 3</th>
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<td>10/5/2012</td>
<td>OBSTR INCISIONAL HERNIA</td>
<td>ACUTE RESPIRATORY FAILURE FOLLOWING TRAUMA AND SURGERY</td>
<td>OLIURHIA &amp; ANURIA</td>
<td>UNC HOSPITALS</td>
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<tr>
<td>9/9/2012</td>
<td>9/11/2012</td>
<td>URIN TRACT INFECTION NOS</td>
<td>REGIONAL ENTERITIS NOS</td>
<td>BIPOLAR DISORDER UNSPECIFIED</td>
<td>UNC HOSPITALS</td>
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<tr>
<td>8/21/2012</td>
<td>8/27/2012</td>
<td>DIABETES MELLITIS W/O COMPLICATION, TYPE II; UNCONTROLLED</td>
<td>NONHEALING SURGICAL WOUND</td>
<td>HYPOGAMOLALITY</td>
<td>UNC HOSPITALS</td>
</tr>
<tr>
<td>1/19/2012</td>
<td>1/21/2012</td>
<td>ABDOMINAL PAIN, OTHER SPEC. SITE</td>
<td>REG ENTERITIS, SM INTES</td>
<td>ANEMIA OF OTHER CHRONIC DISEASE</td>
<td>UNC HOSPITALS</td>
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<tr>
<td>9/7/2011</td>
<td>9/30/2011</td>
<td>PERSIST POSTOP FISTULA</td>
<td>INTESTINAL FISTULA</td>
<td>REGIONAL ENTERITIS NOS</td>
<td>UNC HOSPITALS</td>
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<tr>
<td>9/9/2011</td>
<td>9/7/2011</td>
<td>REGIONAL ENTERITIS NOS</td>
<td>BIPOL AFF, MIXED-UNSPEC</td>
<td>ANAL FISTULA</td>
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### Emergency Department Visits - 10

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<th>Admit Hour</th>
<th>Primary Diagnosis</th>
<th>Secondary Diagnosis</th>
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<td>HYPERTENSION NOS</td>
<td>ALAMANCE REGIONAL MEDICAL CENTER</td>
</tr>
<tr>
<td>9/9/2012</td>
<td>Sunday</td>
<td></td>
<td>URIN TRACT INFECTION NOS</td>
<td>TOBACCO ABUSE-IN REMISS</td>
<td>ALAMANCE REGIONAL MEDICAL CENTER</td>
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<td>8/17/2012</td>
<td>Friday</td>
<td></td>
<td>OTHER CHRONIC PAIN</td>
<td>ABDOMINAL PAIN, UNSP. SITE</td>
<td>ALAMANCE REGIONAL MEDICAL CENTER</td>
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<tr>
<td>6/26/2012</td>
<td>Tuesday</td>
<td></td>
<td>REGIONAL ENTERITIS NOS</td>
<td>HYPERTENSION NOS</td>
<td>UNC HOSPITALS</td>
</tr>
<tr>
<td>5/23/2012</td>
<td>Tuesday</td>
<td></td>
<td>OTHER CHRONIC PAIN</td>
<td>ABDOMINAL PAIN, UNSP. SITE</td>
<td>ALAMANCE REGIONAL MEDICAL CENTER</td>
</tr>
<tr>
<td>3/18/2012</td>
<td>Monday</td>
<td></td>
<td>ABDOMINAL PAIN, UNSP. SITE</td>
<td>HISTORY TOBACCO USE</td>
<td>ALAMANCE REGIONAL MEDICAL CENTER</td>
</tr>
</tbody>
</table>
Successful local pilot led to the initiation of BHPPs in six additional CCNC networks.
- Collaboratives focus on populations in one county or in one region
- Identify specific project or projects that address aspects of the Triple Aim: improving experience of care, improving health of populations, reducing costs
- A small team of designated individuals including: someone in a position of leadership or who is well-connected with leadership, someone well-versed in QI, someone who interfaces with patients
- IT capability to upload MIDs, access reports, etc.
Key Points

- Eliminate real and perceived barriers to sharing information for treatment, care coordination, and quality improvement
  - Education campaign: sharing information for these purposes is a part of better coordinated healthcare
- Utilize health information exchanges and population health analytics to create shared data systems
- Build relationships!
SHARING HEALTH INFORMATION ACROSS SYSTEMS

New York State Department of Health
Office of Health Insurance Programs

Greg Allen, Policy Director

August 6, 2015
Agenda

1. Current Challenges in Sharing Information Across Systems

2. DSRIP & Performing Provider Systems (PPSs)

3. Data Access in DSRIP

4. Patient Consent and Data Security

5. Open Discussion
Current Challenges in Sharing Information Across Systems
Challenges in Sharing Data Across Systems

1. In some cases, there is no existing legal relationship between providers that requires them to share data.

2. Patient consent is required to share data across providers of separate health systems, both related to sharing, accessing, or conduct analysis.

3. Health technologies need to be adapted to allow for seamless interoperability.

4. Consistent Data standards and data governance need to be standardized across providers in the system to optimize usability, accuracy, and integrity of the data.
## Policy Standards to Consider When Structuring Data Integration

<table>
<thead>
<tr>
<th>Policy Standards</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participation Agreement</strong></td>
<td>Require participants to comply with exchange Policy Standards</td>
</tr>
<tr>
<td><strong>Consent Management</strong></td>
<td>Ability to track the patient has given express consent to access clinical Protected Health Information; exceptions apply</td>
</tr>
<tr>
<td><strong>Authorization</strong></td>
<td>Process for determining whether a particular individual within a Participant has the right to access Protected Health Information via the exchange</td>
</tr>
<tr>
<td><strong>Authentication</strong></td>
<td>Verifying that an individual who has been authorized and is seeking to access information via the exchange is who he/she claims to be</td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td>Access controls govern when and how a patient’s information may be accessed by Authorized Users</td>
</tr>
<tr>
<td><strong>Audit</strong></td>
<td>Oversight tools for recording and examining access to information and are necessary for verifying access controls</td>
</tr>
<tr>
<td><strong>Breach</strong></td>
<td>Minimum standards Entities and Participants will follow in the event of a breach</td>
</tr>
</tbody>
</table>
DSRIP & Performing Provider Systems (PPSs)
2014 MRT Waiver Amendment

- Medicaid Redesign Team (MRT) convened January 2011 to develop an action plan to reshape the Medicaid system to reduce avoidable costs and improve quality.

- In April 2014, Governor Andrew M. Cuomo announced that New York State and CMS finalized agreement on MRT Waiver Amendment.

- Part of the MRT plan was to obtain a 1115 Waiver which would reinvest MRT generated federal savings back into New York’s health care delivery system.
DSRIP Explained

- Short for: “Delivery System Reform Incentive Payment” Program
- Overarching goal is to reduce avoidable hospital use – ED and inpatient– by 25% over 5+ years of DSRIP
- This will be done by developing integrated delivery systems, removing silos, enhancing primary care and community-based services, and integrating behavioral health and primary care.
- Built on the CMS and State goals in the Triple AIM
  - Improving Quality of Care
  - Improving Health
  - Reducing Costs
Performing Provider Systems (PPS)

- Partners include:
  - Hospitals
  - Health Homes
  - Skilled Nursing Facilities
  - Clinics & FQHCs
  - Behavioral Health Providers
  - Home Care Agencies
  - Physicians/Practitioners
  - Other Key Stakeholders

- Community health care needs assessment based on multi-stakeholder input and objective data.
- Building and implementing a DSRIP Project Plan based upon the needs assessment in alignment with DSRIP strategies.
- Meeting and reporting on DSRIP Project Plan process and outcome milestones.
Performing Provider Systems (PPS)

25 Performing Provider Systems
Data Access in DSRIP
DEAA, Opt-out Process, MAPP, RHIOs, & SHIN-NY
Process Flow for Release of Medicaid Data

Legend:
**Purple Arrow** – Path for Accessing in MAPP
**Blue Arrow** – Path for Accessing Outside MAPP

1. PPS Lead completes DEAA Addendum
2. PPS Lead allowed to receive PHI data (with restrictions)
3. Data made available through DOH-CMA secure file transfer
   - To receive data, PPS Lead needs to work with CMA to set up secure file transfer in their environment
4. Opt-out process completed
5. PPS Lead allowed to grant access to DOH Medicaid data for remote users within its own organization (but not to downstream partners)
6. PPS Lead may view DOH Medicaid Data via MAPP (when available)
7. PPS Lead allowed to grant access to DOH Medicaid data to downstream partners

PPS Lead completes Security Affidavit and implements prescribed security controls
In order for a PPS lead to receive permission from the state to access PHI Medicaid data from the State, they must agree to and submit a DEAA Addendum to the State.

PPS submits a Security Assessment to the Department that certifies that they have implemented necessary Security Protocols in order to receive PHI (2FA).

Once Opt-Out Process (following slide) is complete and additional Security Assessment Affidavits completed, data can be shared with downstream partners by the lead PPS.
NYS is modeling the DSRIP consent process on the Medicare ACO model which is an opt-out model.

Unless member formally opts-out of DSRIP data sharing, they are considered participating in data sharing.

To “opt-out” means electing NOT to permit the sharing of any PHI and other Medicaid data held by the state with the PPS and its partners.

The member who “opts-out” will not have his/her Medicaid data shared with the PPS Lead Entity and partners.

A member can opt-out or opt-in for data sharing at any time.
To begin the data sharing process, Medicaid has contacted all members by mail and is providing each an opportunity to opt-out of the DSRIP data sharing with the PPS and partners.

Until this first “opt-out” process cycle is complete, DOH-supplied PHI information cannot be shared with the PPS downstream partners.

Medicaid will present the opt-out information to new members when they enroll.

The DSRIP opt-out process only covers DOH Medicaid data that is shared with the PPS.
Letter meets federal and state requirements related to PHI and privacy based upon review by NYS DOH, OMH, and OASAS

Over 6 million letters have been released this summer to Medicaid members

Medicaid members have 30 days to respond

A process has been built for finding alternative addresses for returned mail

The initial Opt-Out process is scheduled for completion end of December 2015
New York State Health Home Model

Managed Care Organizations (MCOs)

New York State Designated Lead Health Home
Administrative Services, Network Management, HIT Support/Data Exchange

Health Home Care Management Network Partners (includes former TCM Providers)
- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Support Services
- Use of Health Information Technology to Link Services (Electronic Care Management Records)

Access to Required Primary and Specialty Services
( Coordinated with MCO)
- Physical Health
- Behavioral Health
- Substance Use Disorder Services
- HIV/AIDS
- Housing
- Social Services and Supports

MAP

RH IO
Outreach program fueled by limited claims and encounters pre-consent.

Assertive consent (not opt out) gathered at enrollment.

One Consent covers physical, mental health and substance use disorder.

One Consent form covers entire health home network (not one at a time).

Working with RHIOs to do multiparty consent.
First stage of MAPP development includes:

- Moving current Health Home Member Tracking System to a Web-Based Portal.
- Providing Health Homes, Care Management Agencies and Managed Care Plans access to Medicaid Data Warehouse and Salient analytics to provide additional monitoring and performance management capabilities.
- Developing a Web-based referral tool.

Subsequent stages will include enhanced management capabilities and access to a care management record system (Curam).
MAPP will be a key tool in shifting focus of the program from start up to performance by providing MCOs, Health Homes and care managers access to analytical tools and data to actively manage the program and achieve better outcomes.

- Access to Data and Performance Analytics will be:
  1. Transparent: Plans, Health Homes, Care Managers and the State all have access to the same performance data
  2. Useful as a Management Tool: Data views will be useful, timely and actionable data
  3. Easily Accessible: Easy to deploy and use without significant training (Dashboard displays of data)
Providing data that is timely, accurate, and easily accessible to support population health analysis and inform treatment decision-making is critical to DSRIP’s success. It is therefore critical that PPS providers make clinical data available to other PPS providers by connecting with their Regional Health Information Organization (RHIO).

As of July 1, 2015 the RHIO completed their certification process and have now become Qualified Entities (QE).

QEs are devoted to developing and deploying interoperable health information technology and analytics to facilitate patient-centric care across health settings.

There are 9 QEs in New York State, each storing sharing electronic health information for the providers in a distinct geographic area.
Core Minimum Services

- The QE’s will provide a secure environment that protects patient information.
- Patient Record Lookup and Secure Messaging are being implemented on a statewide basis.
- There are eight core services that will be provided by each Qualified Entity.
- The core services support management of patient identities across Providers, Networks, and Regions.
- The core service give Providers access to public health data.
- The QE will be able to deliver alerts and results to Providers.

Core Minimum Services:

- Patient Record Lookup (Community)
- Patient Record Lookup (Statewide)
- Secure Messaging Direct
- Consent Management
- Notification (Alerts)
- Identity Management & Security
- Provider and Public Health Clinical Viewer
- Public Health Integration
- Result Delivery
# QE Minimum Core Services & Additional Integration Services Currently Provided

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1 – Healthix currently does not have a patient portal exposed to the patients, but it may have the capability.

2 – Rochester Patient portal does not provide link to patient medical information. The portal described on their website is not a patient portal as defined by Meaningful Use. It may have the capability to provide a patient portal as defined by Meaningful Use.

### Legend

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<tr>
<td>N/A</td>
<td>Information Not Available</td>
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</table>
The Advantages of Data Integration through QEs

- QEs will be able to initiate the integration process as soon as data dictionaries for the Medicaid Claims Database are shared.
- Since clinical data is shared by multiple PPSs, the QEs will be able to produce meaningful comprehensive and cross-PPS analytics using the integrated data.
- Integrated data will be very useful for:
  1. Data Analytics
  2. Population Health Management
  3. Understanding cost and effectiveness of treatments
  4. Measuring DSRIP projects’ success
The SHIN-NY is a “network of networks” that links New York’s nine QEs throughout the State.

With patient consent, the QE allows those records to be accessed securely by other healthcare providers.

As part of the SHIN-NY, QEs will be able to exchange records between each other, creating a statewide network of health information.

This “network of networks” is the keystone of the State’s strategy of safely and securely sharing accurate and useful health data through the DSRIP Program.
Sharing Data Across Systems – Policy and Operational Considerations

- Legal access to data
- Consent requirements (clinical)
- Security requirements (Medicaid > QE Policy Standards)
- Security audits for non-certified entities
- Analytic standards (comparative quality measures across PPSs)
- Data governance (MDM algorithm, data access, etc.)
- Data cleansing/validation
- Data storage and system processing optimization
- Initial/Ongoing costs and funding mechanisms
- Sustainability Models beyond DSRIP/HITECH
- Compliance with current and future regulations
Patient Consent & Data Security
Prior to going through the Opt-out process for patient consent, each PPS will have to determine how they intend to access the Medicaid data provided by the New York State DOH

- If the PPS decides they don’t want to store the data within their organization they will use the MAPP tool to access Member roster and claims extract files for their attributed population.
- If however, a PPS does want to store the Medicaid data of their attributed members within their organization they will have to follow several steps to ensure the security of that data because the Medicaid data files contain PHI.

The PPS lead entity will have to have a secure server where they can store the files and they will need to designate two tech savvy users with accounts on the server who will be able to retrieve and decrypt the DOH provided data that contains the PHI.

The two users accessing the PHI will need IAL 3 which includes in-person identity proofing using a government issued ID along with two factor authentication tokens (2FA tokens).
Data Security through Two-Factor Authorization

- 2FA (Two-Factor Authorization) will be implemented by August 2015.
- The initial 2FA implementation will require users to have a NYS DMV-issued identification.
- 2FA tokens are a state approved form of identification that is usually something you have, that can only be unlocked by something you know or something you are.
  - For example a certificate (something you have) is unlocked by a passcode (something you know) and the combination of the two provides the user access to the protected information.
Patient Consent - Process

The process flow for the file transfer is as follows and outlined in the model below:

1. The PPS lead entity requests the member roster file and claims extract file from the MAPP tool.
2. The MAPP tool will send an encrypted file containing the member roster and claims extract to a secure FTP.
3. Once the file is in the FTP the authorized and identified users will log in and download the file to the lead PPS secure server.
4. The two identified users will then decrypt the file to unlock the data for PPS use.
5. The two identified users access and analyze the data.
Domain Scorecard

Measures as of DEC. 30, 2015 | Month 7 of 12

PPV (for persons with BH diagnosis) per 100

On Target! ▼0.7

Cardio Monitoring for People w/ Cardio Disease and Schizophrenia

On Target! ▲1.5%

Diabetes Screening for People w/ Schizo./BPD Using Antipsychotic Med.

Not on Target ▼7%

Antidepressant Medication Management--Effective Acute Phase Treatment

High Performance! ▲6%

Follow-up care for Children Prescribed ADHD Medications - Initiation Phase

On Target! ▲2%

Follow-up care for Children Prescribed ADHD Medications - Continuation Phase

Not on Target ▼8%

Description of Measures

Numerator Description
Number of children who had one follow-up visit with a practitioner within the 30 days after starting the medication.

Denominator Description
Number of children, ages 6 to 12 years, who were newly prescribed ADHD medication.
PPV (for persons with BH diagnosis) per 100

On Target! ▼ 0.7

Trend

Range

Past 12 Months

Base Case

Monthly Target Zone

Monthly High Perf. Zone

Gender

Age Group

CRG

Geography

Score Distribution

PCP

# Members

PPV (for persons with BH diagnosis)

PPS

117

23

PPS Hub

45

12

HH

5

9

HH Care Management Agency

16

8

MCO

42

6

Dr. Otilia Roitel

21

3

Dr. Earl Castro

19

2

Dr. Erlinda Visser

23

2

Dr. Brandee Vaughn

12

2

Export Data
State Solution Performance Dashboards

…to Member detail

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<th>Dr. Carl Tucker</th>
<th>CIN</th>
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Questions?

**DSRIP e-mail:**
dsrip@health.state.ny.us
Question and Answer

Please use the chat box at the bottom of your screen to ask a question.
Thank you

- Please complete our evaluation on the next slide.