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Behavioral Health EHRs - What Vendors Need To Know
Introduction

Lori Simon, MD
June 27, 2014

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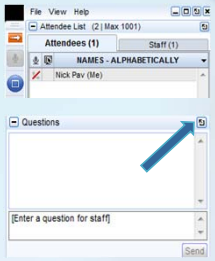
Webinar Housekeeping

- **Minimize/maximize panel by clicking the arrow**
- **To be recognized, type your question in the "Question" box**
- **If the dialog box disappears, click the arrows at the top of the small box to type a question**



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My Background

- 18 years in the computer field, including 13 with IBM, prior to becoming a physician.
- Software developer for a variety of applications in banking and internal IBM systems.
- Programmer, systems analyst, project leader, database specialist.
- Helped install IBM's Patient Care System in Stony Brook University Hospital prior to hospital opening.
- Served as a "super user", assisting with the implementation of the EPIC EHR in a major hospital in New Jersey (2010).

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My Background

- Systems Engineer/Health Industry Specialist supporting IBM's NYC healthcare customers. Involved with joint development project between IBM and New York Presbyterian – Columbia University Medical Center to develop a clinical decision support system.
- Then, decided to go to medical school!! Practicing Psychiatrist for 14 years.

 4

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Most Important Lesson

Importance of Involving Users In Every Aspect of Software Development

- Design, Testing, Documentation, Implementation (every phase, except code walkthroughs!!).
- Strong IT Departments within Banking, Insurance, Media Industries.

 5

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Healthcare -> Minimal User Involvement

- Weak IT Departments in Hospitals --> primarily due to funding problems.
  - Not sufficiently determining user requirements.
  - Not sufficiently overseeing testing, training, and implementation.
- Solo/Small Group Practices
  - Don't have time or financial resources.
  - Too many entities for vendors.

 6

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Solution

- Stronger IT Departments.
- Professional Societies Working Closely With Vendors to represent needs of their members.

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Agenda

- Potential Marketplace for Behavioral Health EHRs (Dan Balog MD)
- Behavioral Health Activities
  - APA/MHIT Committee (Steve Daviss MD)
  - AACAP (American Association Child Adolescent Psychiatrists) (Alan Axelson MD)
  - SAMHSA (Substance Abuse Mental Health Services Administration) (Jim Kretz)

 8

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Agenda

- Behavioral Health Activities
  - Requirements Consolidation (Lori Simon MD)
  - HL7 Organization (Ioana Singureanu)
  - ONC (Office National Coordinator) (Amy Helwig MD, Larry Wolf)
- Q&A's (10 min.)

 9

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Agenda

- Behavioral Health Issues
  - Privacy/Security (Zebulon Taintor MD)
  - Health Information Exchanges (Steve Daviss MD)
  - Terminologies, Governmental Reporting (Lori Simon MD)
- Q&A's/Vendor Feedback (10 min.)
- Concluding Remarks (Lori Simon MD)

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BIOs

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Alan Axelson, MD

Alan Axelson, a board certified child and adolescent psychiatrist, leads InterCare Psychiatric Services, a multidisciplinary psychiatric outpatient practice located in Pittsburgh serving children, adolescents and adults. InterCare also provides psychiatric services to community clinics and adolescent drug and alcohol treatment facilities. It uses EMR technology to efficiently manage the team based care it provides. He is a founding member of the American Academy of Child and Adolescent Psychiatry committee dealing with the economics, structure and technology of psychiatric practice with the goal of improving access to care and currently serves as the co-chair of that committee. He just completed participation in the AACAP strategic planning process, Back to Project Future, as a member of its Steering Committee.

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Daniel J. Balog, MD

Dr. Balog is an Assistant Professor in the Department of Psychiatry, Uniformed Services University in Bethesda Maryland. He received dual GME training in Adult Psychiatry and Family Medicine from the National Capital Consortium, Walter Reed National Military Medical Center, and prior to his current assignment, served as the Deputy Chief Medical Information Officer (CMIO) at Air Force Medical Support Agency, Office of Air Force Surgeon General. Dr. Balog also served as a contributor to the DSM-5 Psychiatry and Primary Care Interface Group.

Today Dr. Balog will address how recent changes in Behavioral Health Care combined w/ Health IT and regulatory advances will impact EHR marketplace in a variety of medical care settings.

13

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Steve Daviss, MD

Steve Daviss is a physician double-boarded in Psychiatry and in Psychosomatic Medicine, which is the intersection of primary care and psychiatry. He is the recent past Chair of the Department of Psychiatry at Baltimore Washington Medical Center, and is Clinical Assistant Professor in the University of Maryland School of Medicine, where he also attended medical school. He trained at the University of Pittsburgh Medical Center at Western Psychiatric Institute and Clinic. He completed an NIMH-funded clinical research fellowship in schizophrenia at the Maryland Psychiatric Research Center.

Dr. Daviss is a Distinguished Fellow of the American Psychiatric Association. He is Chair of the APA Committee on Mental Health Information Technology, APA Assembly Representative for Maryland, Past-President of the Maryland Psychiatric Society, and is active in the Legislative Committees for Medchi and for the MPS. He has served as past co-chair of the CCHIT Behavioral Health Work Group, where he helped direct the development of certification standards for behavioral health electronic health records with a diverse group of clinical, informatics, and vendor stakeholders. He has served on URAC's Health Standards Committee since 2004, and also serves on the Maryland Health Care Commission's Health Information Exchange Policy Board, the Maryland Department of Health and Mental Hygiene's Behavioral Health Integration Work Groups, and the Clinical Committee for the Chesapeake Regional Information System for our Patients (CRISP), Maryland's state-designated HIE. Dr. Daviss is the Chief Medical Information Officer for M3 Information, LLC, a DC-based mobile mental health IT company that developed the NCQA-recognized multidimensional mental health screening and tracking tool, M3 Clinician.

Dr. Daviss is a member of the American Psychiatric Association, American Medical Informatics Association, American Association for Technology and Psychiatry, American Medical Association, Academy of Psychosomatic Medicine, HL7, HIMSS, Maryland HIMSS, Maryland Psychiatric Society, Medchi, and the Southern Psychiatric Association.

14

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Steve Eichner

Steve Eichner is the HIT Policy Project Manager at the Texas Department of State Health Services (DSHS). Steve is responsible for helping develop and advance the agency's use of information technology to improve service delivery and reporting systems. Among other activities, Steve has worked on the DSHS Health Services Gateway, state public health information systems used to support CMS' EHR incentive programs, and the Clinical Management for Behavioral Health Services system, an electronic health record and reporting system for DSHS contractors.

15

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Laura Fochtmann, MD, MBI

Dr. Laura Fochtmann is a Professor of Psychiatry, Pharmacological Sciences and Biomedical Informatics at Stony Brook University. She is also Medical Editor of the American Psychiatric Association's Practice Guidelines. Previously, Dr. Fochtmann has served as a member and as chair of APA's Committee on Electronic Health Records (EHRs). Her formal education and training includes degrees in Electrical Engineering, Medicine and Biomedical Informatics as well as residency in Psychiatry and fellowship training in Clinical Pharmacology. She is board certified in Psychiatry and in Clinical Informatics.

Dr. Fochtmann's interest in computers began in elementary school under her father's tutelage in an era of mainframe computers, punch tape and acoustically coupled modems. More recently, she has been involved with Stony Brook Medicine's EHR implementation in inpatients, emergency and outpatient psychiatric settings. She is particularly interested in psychiatrists' use and synthesis of information at the point of care and the ways in which practice guidelines can be delivered in customized formats to enhance the quality of care that patients receive.

16

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Amy Helwig, MD, MS

Dr. Amy Helwig serves as a Medical Officer in ONC's Office of the Chief Medical Officer. She brings government and private sector experience to quality and safety activities including data analytics for population health management, standards development for clinical decision support, and e-clinical quality measures for meaningful use.

Previously, Dr. Helwig served at AHRQ's Center for Quality Improvement and Patient Safety as the team lead and senior clinician for AHRQ's Patient Safety Organization Program. At AHRQ she led the implementation of the Patient Safety and Quality Improvement Act and the development of common formats for patient safety event reporting and national database analysis. Additionally, Dr. Helwig was involved in development of triggers for adverse event detection, patient safety culture, and clinical team safety training programs

Dr. Helwig is a board certified family physician a graduate of the Medical College of Wisconsin. Prior to government, she served as Associate Corporate Medical Director at Quad/Med, the medical division of Quad/Graphics, in Sussex, WI where she also practiced family medicine and directed their unique multi-state health care and disease management system that offered on-site primary care clinics for employees and families of Quad/Graphics.

17

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Jim Kretz

Jim Kretz, formally trained in mathematical sociology at Indiana University, is SAMHSA's voting representative to HL7, a medical informatics standards development organization, and various interagency workgroups dealing with health information technology. Before joining SAMHSA in 2005, he spent almost thirty years developing both clinical and healthcare administrative systems including the first comprehensive EHR for Reproductive Endocrinology and Infertility Practices, medical eye bank tissue management, the largest clinical trial (300,000+) of a new medical device, redesigned one of WebMD's claims clearing houses, and developed the first medical billing service accredited to submit claims electronically to the District of Columbia's Medicaid Program. Between 2006 and 2008, he was the primary organizer for the creation of the ANSI Standard Behavioral Health EHR Functional Model. He is a co-chair of the HL7 Community Based Collaborative of Care Work Group and a recently nominated member of HL7's policy advisory committee.

18

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Todd Peters, MD

Todd Peters, MD, is an inpatient child/adolescent psychiatrist and Assistant Professor in the Department of Psychiatry at Vanderbilt University. He is also an Assistant Chief Medical Information Officer at Vanderbilt University Medical Center. He is currently the co-chair for the Health Information Task Force for the American Academy of Child and Adolescent Psychiatry (AACAP) and serves as the AACAP representative for the APA's Committee on Mental Health Information Technology.

 19

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Lori Simon, MD

Dr. Simon has been a practicing psychiatrist for the past 14 years with a solo private practice in both New York City and northern New Jersey for both psychotherapy and psychopharmacology. She is board certified in both adult psychiatry and psychosomatic medicine and a member of the volunteer faculty of New York Presbyterian Weill Cornell Medical Center where she teaches psychiatry to second year medical students. Prior to becoming a physician, Dr. Simon worked for 18 years in the computer field, including 13 years with IBM. During that time, she was responsible for developing and implementing a variety of software applications, as well as serving as a health industry specialist/systems engineer providing technical support to IBM's healthcare accounts in New York City. She assisted with the implementation of IBM's Patient Care System (PCS) in Stony Brook University Hospital shortly before it opened and was heavily involved in the contract IBM had with Columbia University Medical Center's Department of Bioinformatics to develop a clinical decision support system. She was also a relational database specialist and developed a strategy for the use of speech recognition in healthcare. In addition, she taught systems analysis as an adjunct professor at New York University and spent 10 weeks studying advanced computer science topics within IBM's highly competitive Systems Research Institute (SRI) where her focus was on Artificial Intelligence. In 2010, she served as a "super user", assisting with the implementation of the EPIC EHR in a major hospital in New Jersey.

Dr. Simon is currently a member of the American Psychiatric Association's (APA) MHIT Committee where she has been the primary developer of a detailed set of functional requirements for an EHR used by psychiatrists. She has also written a document containing specific guidelines for the selection and implementation of an EHR which is available on the APA's website and chaired a symposium on "Getting Started With An EHR In Your Practice" at the APA's Annual Meeting in May 2013. During medical school and residency, she spent 4 years serving as the American Medical Informatics Association's first Student Working Group chairperson.

Dr. Simon is equally passionate about mental health. In addition to her private practice, she has worked part time in a variety of clinical settings, including a psychiatry ER and on the psychiatry consult service for inpatient medical/surgical units. She also spent 8 years working part time for organizations in New York City providing psychiatric services for the homeless and other underserved populations, even working, at times, in shelters and on an ACT team.

 20

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Ioana Singureanu

During her twenty years of experience in software development, information integration, and software architecture, Ms. Singureanu has been consistently involved in healthcare integration standard development and implementation (past HL7 Conformance co-chair, current HL7 Modeling and Methodology co-chair, past HL7 Technical Steering Committee member) thus ensuring that best industry practices are reflected in standards produced by consensus-based bodies while applying healthcare Information Technology (IT) standards to accelerate the adoption of interoperable electronic health record systems and medical devices in healthcare. As a technical consultant, Ms. Singureanu collaborated with leading healthcare organizations, vendors and consortia (e.g. IHE, HITSP, MITA) to design, implement, and deploy strategic architecture as well as integration solutions for automating various healthcare delivery processes and improve the quality of care and patient safety. The solutions and architecture reflected industry best-practices and used proven software tools and design methodologies to best meet the clients' needs.

Ms. Singureanu holds a Master's Degree in Computer Science and a Bachelor's Degree in Electrical Engineering from University of Massachusetts, Lowell. She is a co-founder of Eversolve, LLC a healthcare interoperability consulting practice.

In this capacity, Ms. Singureanu has been involved in developing standards to provide consistency for healthcare privacy and security infrastructure in for open distributed systems (e.g. Nationwide Health Information Network – NHIN). Ms. Singureanu has been working closely with government (e.g. SAMHSA, VA, SSA) and private sector stakeholders (e.g. vendors like GE, Philips, Microsoft and providers like Kaiser Permanente) to create standards that promote the adoption of a security architecture that supports the mosaic of privacy policies specified for the systems of today, as well as anticipating the needs of Electronic Health Records Systems that meet the criteria for meaningful use. The result of this collaborative work has been the creation of two releases of an information model as a standard-based representation privacy and security needs in healthcare (including support for consumer as defined by the ONC Consumer Consent requirements). This model was used to derive a draft "Security and Privacy" specification in the FHA Health Information Model (FHIM) under the auspices of the Federal Health Information Modeling and Standards (FHIMS) Work Group. The standard was used to deriving document-based representation of consumer consents (e.g. using Clinical Document Architecture - CDA) and to pilot a standard-based access control approach to consent enforcement based on segmented data. These specifications are extensible and reusable to allow EHR Systems to exchange consumer consents and privacy policies using standard-based and platform-neutral representations (.e.g. CDA right, NIEM in the future, etc.).

 21

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Zebulon Taintor, MD

Dr. Taintor got involved with computers and data bases through epidemiology in Nigeria as a medical student. As a resident he wrote a program to make DSM II diagnoses from interview data. He directed the Multi-State Information System from1975-79, developed workforce and economic data at NIMH. He edited a book and has published numerous articles on the uses of computers in psychiatry. He has been active in APA work on computers for decades, chairing a committee that evolved from reviewing APA's use of computers into a large group, open to all, that promoted use of technology in psychiatry. This became the American Association for Technology in Psychiatry, of which he was a founding member and serves on the Steering Committee. He also chaired the APA Committee on Telepsychiatry and has served on the Committee on Quality Indicators. He has served as a member of the APA Committee on Electronic Health Records (EHRs) since its formation..

He chaired MSSNY's Health Information Technology (HIT) Committee and its related Task Force. MSSNY secured a $9 million grant from the NYS legislature to promote the use of electronic prescribing, electronic health records (EHRs), and participation in regional health information organizations. Through the NYU-OMH WHO Collaborating Center for Statistical Sciences and Epidemiology at the Nathan Kline Institute for Psychiatric Research he has consulted to other countries on mental health information systems. He served on the privacy and compliance work group of the Certification Commission for Health Information Technology and. co-chaired the behavioral health work group He is an adjunct professor of psychiatry at New York University School of Medicine. He has organized EHR privacy symposia for APA annual meetings.

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Larry Wolf

Larry Wolf is the Health Information Technology Strategist at Kindred Healthcare. He has been with Kindred for twenty-seven years and has over thirty-five years experience in health IT with emphasis on clinical systems across a wide spectrum of care settings. He is exceptionally able to work across traditional boundaries, bridging the technical, clinical and business worlds. He has good rapport with hands-on clinicians and business leaders. He can build consensus and shared vision, even among the conflicting positions of members of Federal workgroups. Larry works with Kindred market leaders to develop strategic partnerships with outside organizations that include other providers and health information exchange organizations. He is well aligned with our Care Management Division.

As the co-chair of the Federal Health IT Policy Committee's Certification and Adoption Workgroup, is currently leading the work to define voluntary certification standards for EHRs in post-acute and behavioral health settings. Larry supported Rick Chapman when Rick was a member of the Federal Health IT Policy Committee, often as Rick's alternate at the Committee meetings.

Larry has a strong foundation in the development of clinical systems going back to the early development of ProTouch. He led the transfer of the ProTouch development group to Kindred from Second Foundation, as well as the transfer of the nursing center clinical systems following the Hillhaven acquisition and the rehab systems from TheraTx. Larry has a track record of strategic use of data. He was one of the early leaders in the creation of Kindred's Data Warehouse group. Since that time, Larry has continued as an advocate for data driven decisions and partnered with executive leaders to support key business initiatives with data. Larry holds leadership positions various industry associations, government advisory panels and participates in national standards activities. He is an organizer of the annual Long-Term/Post-Acute Care Health IT Summit and the biannual LTPAC HIT Roadmap.

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Behavioral Health Future Care: Opportunities for Integration

Daniel J. Balog, M.D.
Committee on Mental Health Information Technology
Daniel.j.balog@gmail.com

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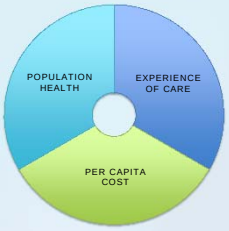
The Promise of Integrated Care

The Triple Aim

- Better Patient Care
- Lower Per Capita Cost
- Better Population Health



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What are Key Challenges?

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Payment Reform

- Limited ways to bill for integrated services
- Alternative payment models such as bundled payments or 'episodes of care' have not been developed
- Current fee for service payment systems do not incentivize value

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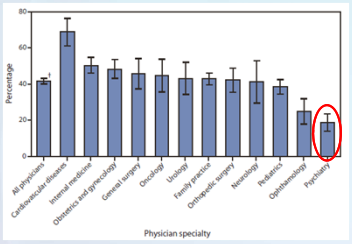
Health Information Technology

Use of Electronic Health Records 2011



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What are Key Drivers?

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DSM-5

- Section I: Basics
- Section II: Diagnostic Criteria/Codes
- Section III: Emerging Measures
  - Cross-Cutting Symptom Measures (Level 1&2)
  - Diagnosis-specific severity ratings
  - WHODAS 2.0 Disability assessment
- Used by all mental health professionals
  - Psychiatry, Psychology, LCSW, NP, PAs
- Used in all medical and MH settings

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DSM-5

- Increased reliance on cross cutting symptom measures and domain assessments to inform clinical care
  - Health IT tools can perfectly complement
- EHR essential to facilitate:
  - Diagnosis (Decision Support)
  - Symptom and Severity Measurement
    - Provide computable Data/decision friendly GUI
    - EHR compatibility w/ data collection devises essential
  - Disability Assessment and Tracking

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Health Information Technology

- Meaningful Use (MU) that is clinically meaningful
- Increasing market for EHR products and that support behavioral health care in various settings!
- Compatibility/workflows that engage patients
  - Web portals
  - mHealth
  - Telepsychiatry

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Business Case for Mental Health

- Healthcare use/costs twice as high in diabetes and heart disease patients with depression[1]

	Annual Cost – those without MH condition	Annual Cost – those with MH condition
Heart Condition	$4,697	$6,919
High Blood Pressure	$3,481	$5,492
Asthma	$2,908	$4,028
Diabetes	$4,172	$5,559

- Untreated mental disorders in chronic illness is projected to cost commercial and Medicare purchasers between $130 and $350 billion annually[2]
- Approximately 217 million days of work are lost annually to related mental illness and substance use disorders (costing employers $17 billion/year)[2]

1. Original source data is the U.S. Dept of HHS the 2002 and 2003 MEPS. AHRQ as cited in Petterson et al. "Why there must be room for mental health in the medical home (Graham Center One-Pager)
2. 2. Hertz RP, Baser CI. The impact of mental disorders on work. *Pfizer Outcomes Research*. Publication No P0002981. Pfizer; 2002.

9

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Role of Behavioral Health in Primary Care

- Many studies have shown that a majority of visits to primary care providers have a Behavioral Health component → Need to capture Behavioral Health data in primary care EHRs.
- Many referrals to Behavioral Health specialists come from primary care providers → Need for Interoperability.

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Behavioral Health Providers (2012)

- 41,000 Psychiatrists
- 96,000 Psychologists
- 193,000 Clinical Social Workers
- 14,000 Psychiatric nurses
- 48,000 Substance Abuse Counselors
- 145,000 Counselors
- 62,000 Marriage and Family Therapists

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What Steps is APA Taking Right Now?

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APA Leadership Initiatives

- BOT Healthcare Reform Strategic Action Workgroup
- Council on Healthcare Systems and Financing/Integrated Care and Medical Home Workgroup
- Patient Centered Primary Care Collaborative
- Performance Measures and Quality Improvement
- Advocacy
- Relationship Building

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New Roles for Consulting Psychiatrists

- Clinical Leader
- Caseload Consultant
- Direct Consultant
- Clinical Educator

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American Psychiatric Association: Committee on Mental Health IT (CMHIT)

Steve Daviss, MD, DFAPA
Clinical Assistant Professor, Univ of Maryland SOM
Chair, APA Committee on Mental Health IT
Pres, Fuse Health Strategies; CMIO, M3 Information
June 27, 2014 ◆ steve@fusehealth.org ◆ @HITshrink

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Different hats

- CMIO, M3 Information LLC
- President & Co-Founder, Fuse Health Strategies
- Clin. Asst. Prof., U of MD School Medicine
- URAC Health Standards Committee
- HIE Policy Board, MD Health Care Commission
- Clinical Advisory Committee, MD's HIE (CRISP)
- Chair, APA Committee on Mental Health IT
- Past Department Chair, Univ. of Maryland BWMC
- Past Co-chair, CCHIT Behavioral Health Workgroup

Fuse

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CMHIT (formerly Committee on EHRs)

- Dan Balog MD - Washington DC
- Steve Daviss MD - Maryland
- Daniel Karlin MD - Massachusetts
- Robert Kolodner MD - Maryland
- Paul Mosher MD - New York
- Ed Pontius MD - Maine
- Lori Simon MD - New York
- Erik Vanderlip MD, MPH - Oklahoma

 41

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CMHIT - Charter

The Committee on Mental Health Information Technology focuses on health information technologies, including electronic health records, personal health records, health information exchange, mobile health technologies, psychiatric informatics, secure messaging for communicating health information, and addressing of relevant health care policies, including state and federal regulations and statutes, on issues relating to mental health information technology, such as privacy, security, patient access, granular consent, data segmentation, usability, clinical decision support, meaningful use, and functionality.

 42

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CMHIT – Recent topics

- Work group for mobile apps
- SAMHSA's DS4P initiative; HIT initiative
- Registries
- ONC Behavioral Health EHR certification
- HL7 workgroups
- Patient access to mental health records
- AmericanEHR
- Health information exchanges
- SNOMED and DSM5
- Privacy and confidentiality

 43

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CMHIT - Contacts

Committee meets by teleconference 2nd Wednesday 6:00pm

Steve Daviss MD	steve@fusehealth.org 410-782-0077
Lori Simon MD	lorir.simon@gmail.com 212-327-1569
Lisa Greiner, MSSA	lgreiner@psych.org 703-907-8624

 44

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Alan A. Axelson, MD, Co-chair
AACAP Committee on Health Care Access & Economics
June 27, 2014

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WHO WE ARE

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

A cohesive organization of well over **8,700** CAPs organized in **65** Regional Organizations.

Communicating through -

* Annual Meeting
  - 2x yearly Assembly meetings
* AACAP News – (6 per year)
* AACAP News Clips (Monday, Wednesday & Friday)
* AACAP Member Emails
* Twitter & Facebook

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SUPPORT

AACAP Committee Structure – *Supporting Innovation*

* Committee on Healthcare Access & Economics
* CPT Sub-Committee connects to AMA structure
* Task Force on Health Information Technology
* Committee on Collaboration with Medical Professionals
* Committee on Community-based Systems of Care
* Committee on Quality Issues

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INNOVATION

Back to Project Future
Recently completed strategic planning initiative- Recommendations:

3.3 - CAPs work in evolving models of healthcare delivery systems including the "Accountable Care Organization" (ACO) and "Medical Home" models.

4.5 - Support collaboration with pediatric primary care and subspecialty physicians in clinical practice.

8.5 - Technology Enhancement - Promote innovative models for practice: e-health, telepsychiatry and multidisciplinary collaboration that expands the reach of CAPs especially to underserved areas.

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SOLUTIONS

Practice Innovation & Technology Enhancements to Deal with Workforce Shortage

* Close collaboration with the American Academy of Pediatrics (AAP) shared education & Tool Kits
* Tele-consultation with pediatric practices
* Team based assessment of children and adolescents
* Co-location of mental health professionals in primary care practices
* School based psychiatric collaboration & treatment

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INFORMATION

Developing EHRs to Support Quality Clinical Care

AACAP Patient Education:

- AACAP Facts for Families
- Medication Guidelines
- Clinical Measurement Tool Kit
- Child & Adolescent Services Intensity Instrument – CASII & ECSII

* AAP: Mental Health Tool Kit
  - When to Refer for CAP Consultation

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SUPPORT

AACAP - EHRs to Address Emerging Problem Issues

Prescription of Atypical of Antipsychotics
- Excessive use of atypical anti-psychotics in children in foster care
- "Choosing Wisely" – Curtail the prescription of atypicals
- Multiple pharmacy precertification requirements

Development of an Integrated Patient Registry
- Basis for population research

Adherence to Treatment Guidelines for ADHD
- Tracking of stimulant Rx – medication diversion

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SUPPORT

For more information:

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www.aacap.org

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SAMHSA HIT Activities

Of Particular Interest or Concern to Software Vendors

42 CFR Part 2

1. **C2S:** Consent to Share Service – a way to have systems automatically attend to a patient's preferences regarding with whom their clinical data will be shared
2. **DS4P:** Data Segmentation for Privacy – a service that enables patients to decide what of their clinical data will be shared with others

BH Providers

ANSI Standard BH EHR Functional Model

1. Contents –1500 functions
2. Conformance

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Behavioral Health EHRs - What Vendors Need To Know
HL7 Requirements Consolidation

Lori Simon, MD
June 27, 2014

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APA MHIT Function Requirements

- Developed in 2012.
- Contains both User and System requirements.
- Available on APA's website: http://www.psych.org/EHR.

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User Requirement Functions

- Appointments
- Billing
- Clinical Charting
- Order Entry
- Patient Access
- General Documentation
- Reports

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Clinical Charting

- Demographics
- Legal (ex. Guardianship)
- Providers/Referrals
- Documentation (ex. Evaluations, Progress Notes)
- Clinical Information
- Problem Lists
- Results

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Clinical Charting – Psychiatry Specific

- Patient Photo
- Legal
- Guardian /Capacity
- Documentation
- Mental Status Examination
- DSM
- Psychiatric History
- Substance Abuse History
- Group Notes

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System Requirements

- Accessability
- Availability
- Authorization
- Decision Support
- Interoperability
- Operating Systems / Platforms Supported
- Support

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MAJOR DESIGN ELEMENTS

- Data fields for each component with required/optional designation (user requirements)
- Detailed requirements for each component
- For each requirement:
  - **Setting** (Inpatient, Private Practice, Clinic, Child/Adol., All)
  - **Priority** for each setting (Essential, Important, Nice)
  - "**Scratchpad" column** for providers to check off which requirements they need and for vendors to indicate which requirements they support. (Full, Partial, None)
- Currently in PDF format

 60

APPOINTMENTS

FIELDS	SPECIFIC REQUIREMENTS	SETTINGS P=Private Practice C=Clinic I=Inpatient Ch=Child/Adol A=All Settings	PRIORITY E=Essential I=Important N=Nice VEND	MEMB	INCLUDED IN EHR F=Full P=Partial N= None
APPOINTMENTS					
Patient Name Appointment Status Employee ID	Overall Component Setting/Priority	P,C	E		
	1) Recurrent appointments.	P,C	E		
	2) Alter calendar time divisions within a day (ex. display 15 min. time slots)	P,C	E		
	3) Sync with other scheduling software (ex. Outlook) on computer /mobile device.	P,C	I		
	4) Schedule provider/practice unavailable time (ex. office closed, vacations)	P,C	I		
	5) Employee ID → ID of employee entering, changing, deleting appt. info.	P,C	I		
	6) Support group appointments.	P,C	N		
	7) Automatically create a billing charge for completed appointments.	P,C	I		
	8) Appointment Status:	P,C	E		
	a. Pending				
	b. Confirmed				
	c. Cancelled, No Reschedule				
	d. Cancelled, Reschedule				
	e. No Show				
	f. Completed				

PATIENT DOCUMENTATION

FIELDS	SPECIFIC REQUIREMENTS	SETTINGS P=Private Practice C=Clinic I=Inpatient Ch=Child/Adol A=All Settings	PRIORITY E=Essential I=Important N=Nice VEND	MEMB	INCLUDED IN EHR F=Full P=Partial N= None
PROGRESS NOTES					
Patient Name/ID DOB **Date of Note** Author Names(s) **Interval History** Plan **Mental Status Exam** Axes (I-V) **Current Medications** Author Signature/Date **Other Fields as Needed by Provider (O)** Psychotherapy Note Indicator	**Overall Component Setting/Priority**	A	E		
	1) Current Medications and Axes I-IV fields to be automatically populated.	A	E		
	2) Ability to customize/create templates based on providers' needs, including MSE input.	A	E		
	3) Support group notes.	A	E		
	4) Ability to automatically add elements of Plan to Reminder List.	A	N		
	5) Ability to print hardcopy or send electronically.	A	E		
	6) Ability to easily view previous notes when creating a new one.	A	E		
	7) Ability to copy sections of a previous note into a new one.	A	I		

PATIENT INFORMATION (CLINICAL)

FIELDS	SPECIFIC REQUIREMENTS	SETTINGS P=Private Practice C=Clinic I=Inpatient Ch=Child/Adol A=All Settings	PRIORITY E=Essential I=Important N=Nice VEND	MEMB	INCLUDED IN EHR F=Full P=Partial N= None
MEASUREMENTS (PHYSICAL)					
	3) Decision Support Warning for abnormal values and notification added to Problem List.	A	I		
	4) Calculate BMI based on Height and Weight.	A	E		
	5) Provide Growth Charts based on Height, Weight, and Age.	Ch	I		
MEDICATIONS					
Medication Name Date Started (O) **Date Stopped (O)** Reason for Stopping (O) **Route of Administration (O)** Frequency (O) **Special Instructions (O)** Source of Information ("Patient", "Provider ", "Pharmacy")	**Overall Component Setting/Priority**	A	E		
	1) Support OTC/"natural" medications.	A	E		
	2) Ability to enter medication history prescribed by other providers.	A	E		
	3) Access medication history from external sources (ex. Surescripts).	A	I		
	4) Ability to select medication from same list of all medications available for ordering. Support partial medication name search and type in free text if medication name not found.	A	E		
	5) Visually show concurrent medication usage.	A	N		

GENERAL DOCUMENTATION

FIELDS	SPECIFIC REQUIREMENTS	SETTINGS P=Private Practice C=Clinic I=Inpatient Ch=Child/Adol A=All Settings	PRIORITY E=Essential I=Important N=Nice VEND	MEMB	INCLUDED IN EHR F=Full P=Partial N= None
COVERAGE LISTS (for on-call or covering clinicians)					
Covering Clinician Name Covering Clinician Phone No. **Patient Name** Patient MRN/ID (R - if I/P) **Patient DOB** Patient Location (R - if I/P) **Patient Phone No. (R - if O/P)** Primary Provider Name **Primary Provider Phone No.** Primary Patient Contact Name & Phone No. **Patient Diagnoses** Patient Medications **To-Do Items (O)** General Notes (O)	**Overall Component Setting/Priority**	I P, C	E I		
	1) Available to both covering clinician and clinician whose patient is being covered.	A	E*		
	2) All Patient fields to be automatically populated once patient's name is selected or MRN/ID entered.	A	E*		
			* if component is provided		

SYSTEM REQUIREMENTS

COMPONENTS	QUESTIONS/ SPECIFICS	SETTINGS P=Private Practice C=Clinic I=Inpatient Ch=Child/Adol A=All Settings	PRIORITY E=Essential I=Important N=Nice VEND	MEMB	INCLUDED IN EHR F=Full P=Partial N= None
ACCESSABILITY					
DATA/SOFTWARE	1) Cloud/remote server support.	P,C I	E I		
	2) Local (Intranet, practice server, and/or PC hard drive) support.	P,C I	E E		
	3) Local (Intranet, practice server, and/or PC hard drive) support for software and customizable subset of data normally accessible from cloud/remote server.	P,C	E		
	4) Mobile (phone, tablet) device support for subset of software/data primarily housed on another computer (ex. PC, mainframe,etc.)	A	I		
	a) Demographics (patient name, DOB, contact info.)				
	b) Current medications.				
	c) Pharmacy Contact Info.				
	d) Problem List.				
	e) Reminders List.				
	f) Appointments.				
	5) Support for DSM-V when it becomes available.	A	E		
	6) Underlying Decision Support mechanism with the ability to add/modify specific warnings.	A	E		

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Certification Commission for Health Information Technology (CCHIT)

- Established in 2004
- 2006 → Began certifying EHRs, including those for Behavioral Health
- Developed extensive requirements and test scripts for Behavioral Health certification

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Requirements Consolidation & Expansion

- Upgrade HL7 Behavioral Health Functional Profile to be compatible with HL7's latest version of their EHR Functional Model.
- Combine Requirements:
  - Behavioral Health Functional Profile
  - APA Function Requirements
  - CCHIT Requirements

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Requirements Consolidation and Expansion

- Incorporate APA Function Requirements Design Elements
- Expand Requirements to other Behavioral Health Settings
- Subject to Full HL7 Org. Oversight Process
- Project in Beginning Stages

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Requirements Database

- Vendors can indicate what requirements they support
- Providers can see which vendors support the requirements they need

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Standard-based Behavioral Health Continuity of Care Information Exchange

HL7 Health IT Standards applied to real-life information exchange

Ioana Singureanu, Eversolve LLC

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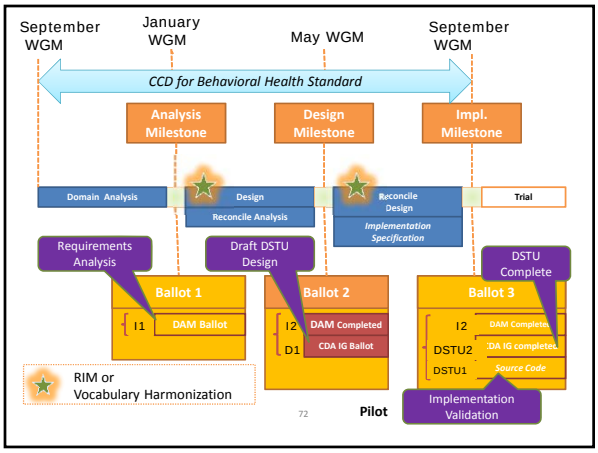
Overview

- Summary document to convey Behavioral Heath (BH) data
  - Use case based
  - HL7 standards based
- Weekly web meetings on Tuesday. @ 1 pm EDT
  - See wiki.hl7.org for detailed information on Community Based Collaborative Care Work Group
  - Reminders will be sent to cbhs@lists.hl7.org
- Analysis of core data elements
  - Content of Consolidated Clinical Documents Architecture (C-CDA) for Behavioral Health consistent with Meaningful Use (Stage 2)
  - Vetted and mapped to C-CDA
  - State and federal reporting requirements



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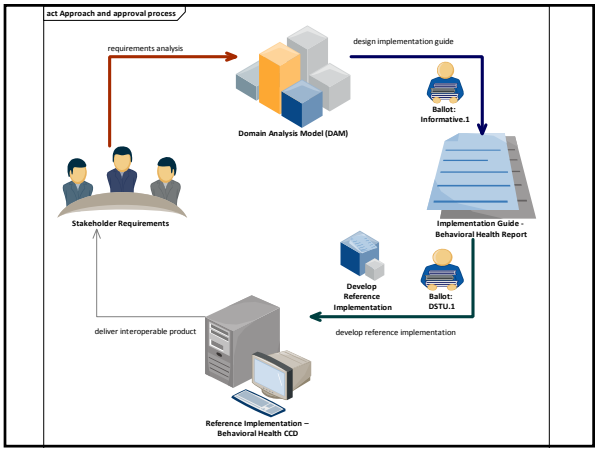
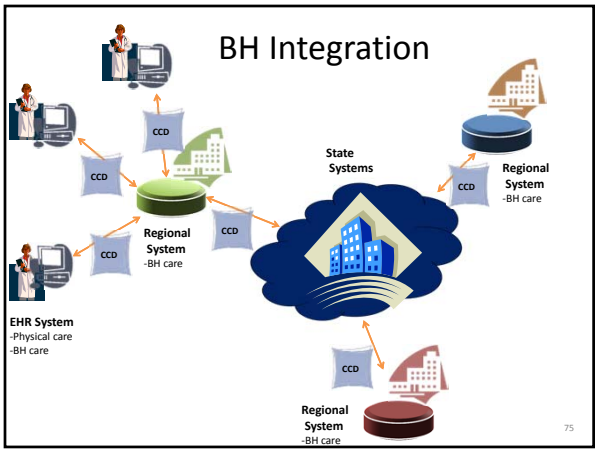
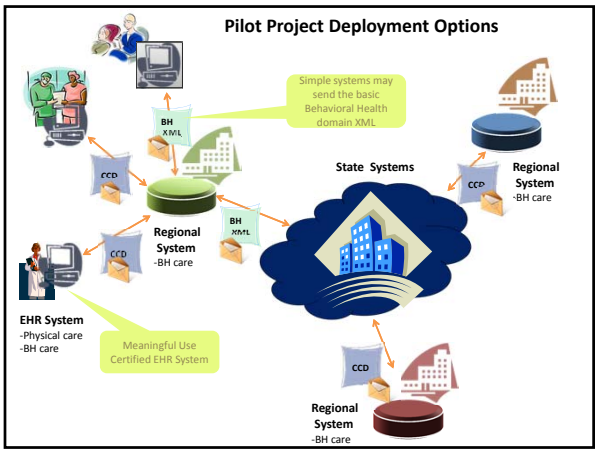
Approach

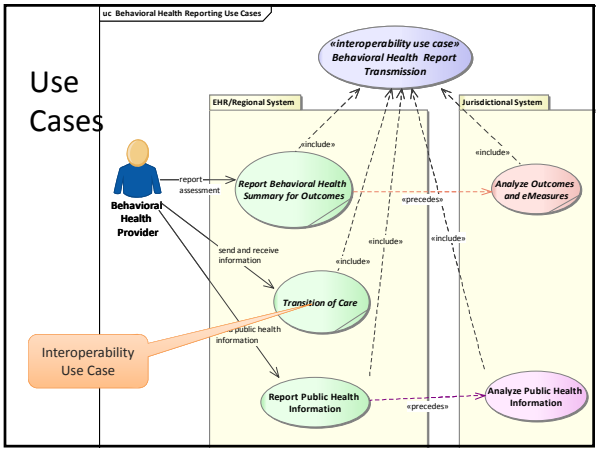
Use case analysis… business requirements
- Regional reporting – recurring, yearly, change in condition, a new document created per update
- Continuity/transfer of care (e.g., referral) – data provenance, transfer between organizations

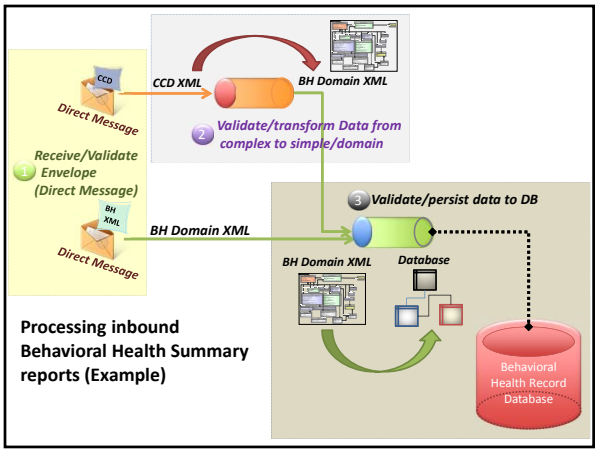
Information requirements analyzed…
- Core data set (mandatory) and state requirements (optional)
  - Information model
- Complete sample CCDs
  - Mapping information requirements to CDA and CCD templates
  - Reuse templates and constructs, add templates when needed
  - Demonstrate how they can be used in this context



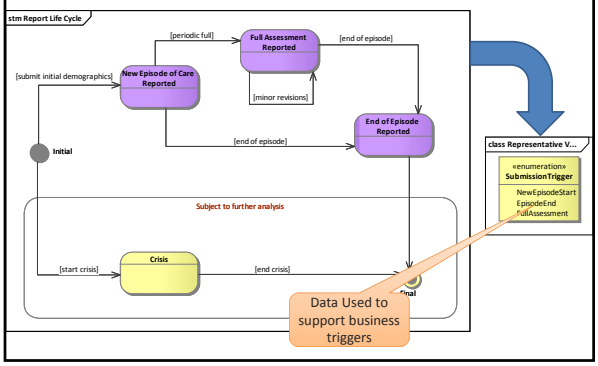



Pilot Project Deployment Options
Simple systems may send the basic Behavioral Health domain XML
BH XML
CCD
State Systems
Regional System -BH care
Regional System -BH care
EHR System -Physical care -BH care
Meaningful Use Certified EHR System
Regional System -BH care


Use Cases
uc Behavioral Health Reporting Use Cases
«interoperability use case» Behavioral Health Report Transmission
EHR/Regional System
Jurisdictional System
Behavioral Health Provider
report assessment
Report Behavioral Health Summary for Outcomes
Analyze Outcomes and eMeasures
«precedes»
«include»
send and receive information
Transition of Care
public health information
Report Public Health Information
Analyze Public Health Information
Interoperability Use Case


CCD
Direct Message
CCD XML
BH Domain XML
2 Validate/transform Data from complex to simple/domain
1 Receive/Validate Envelope (Direct Message)
BH XML
BH Domain XML
Direct Message
3 Validate/persist data to DB
BH Domain XML
Database
Behavioral Health Record Database
Processing inbound Behavioral Health Summary reports (Example)

Report Submission Life Cycle



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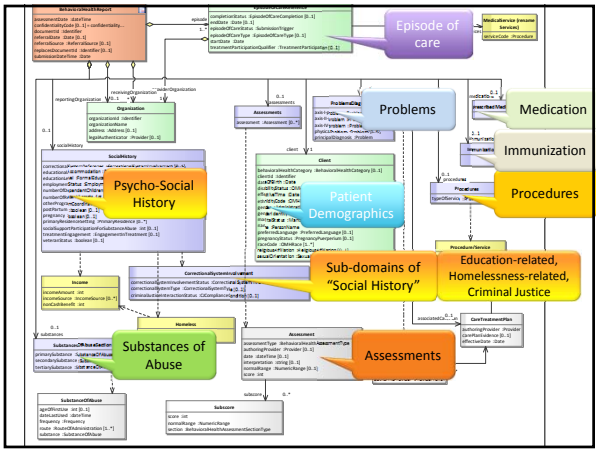
Behavioral Health

Organized along domains
- Patient Demographics
- Episode Of Care
- Assessment
- Problems/diagnoses
- Procedures
- *Medications **
- *Immunizations **
- Substances of abuse

New domains added:
- *Review of systems **
- *Family History **
- *Encounter History **
- New sub-domain for "Mental Status"
- New sub-domain for "Education"

* not elaborated in this data requirements for Behavioral Health – assuming the use of existing interoperability and Meaningful Use standard

- Demographics Domain
- Episode of Care Domain
- Social History Domain
- Assessments Domain
- Problems Domain
- Substances of Abuse Domain
- Procedures Domain
- Medications Domain
- Immunizations Domain
- Family History Domain
- Review of Systems Domain
- Encounter History Domain



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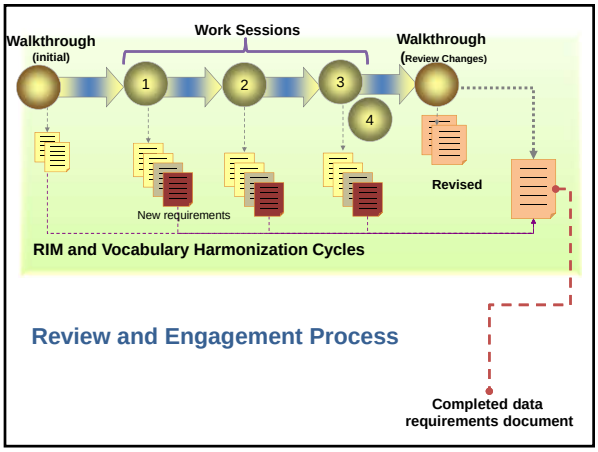
Data Elements: Requirements

New data elements required to support existing and new interoperability requirements
- E.g., last date used

Changes to data elements to represent the information correctly
- Clarify definitions
- Clarify purpose of data
- Specify if a data element is numeric, a range of values, a textual string, a date, a time, a true/false finding, optional/required, repetitions of data elements

Change to value sets for encoded data elements
- Specify a list of allowable values for encoded data elements(e.g. administrative gender, biological gender, etc.)
- Provide complete values/list items, if consensus exists
- Provide representative values/list items (e.g. representative assessment types, assessment sections)



Review and Engagement Process

Completed data requirements document

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Changes applied to the model

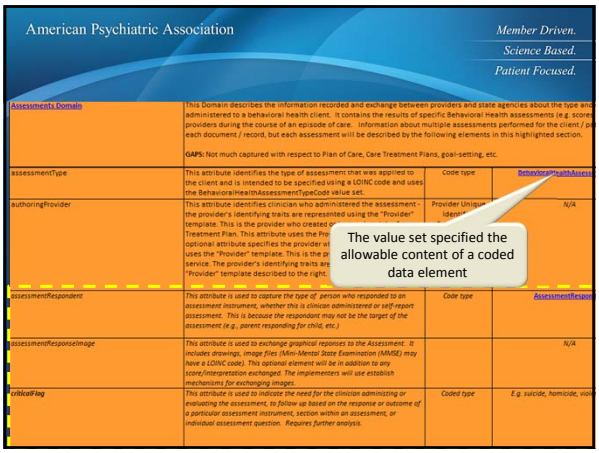
Changes applied to domains
- New sub-domains (Mental Status)
  - Education, Criminal Justice, Veteran Details associated with other state systems
- New domains (Family History, Review of Systems, Encounter History)
- New document types identified as required (H&P, Progress Notes)

New data elements added to domains and sub-domains
- Including associated value sets

Changes to values

Changes/Update to definitions

Renamed data elements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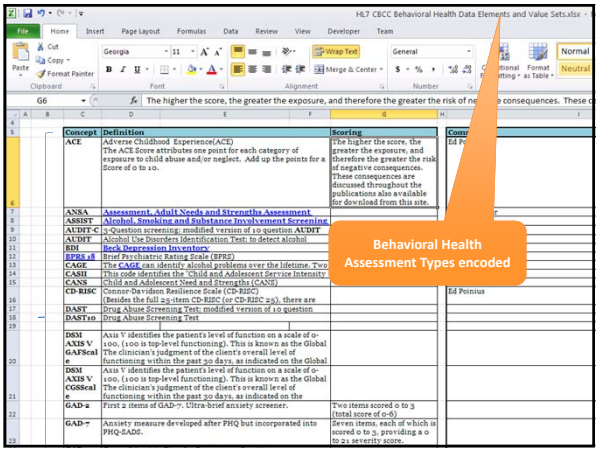
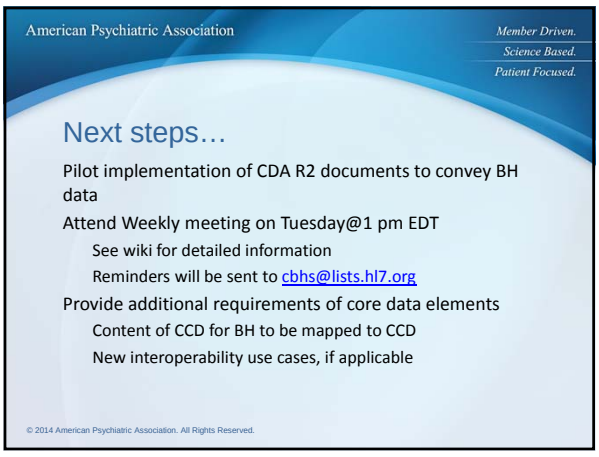
The value set specified the allowable content of a coded data element


HL7 CBCC Behavioral Health Data Elements and Value Sets.xlsx
Behavioral Health Assessment Types encoded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Next steps…
Pilot implementation of CDA R2 documents to convey BH data
Attend Weekly meeting on Tuesday@1 pm EDT
See wiki for detailed information
Reminders will be sent to cbhs@lists.hl7.org
Provide additional requirements of core data elements
Content of CCD for BH to be mapped to CCD
New interoperability use cases, if applicable
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ONC Activities, Voluntary Certification – Recommendations of the HIT Policy Committee

Amy Helwig MD
Medical Officer, ONC Office of Chief Medical Officer
Larry Wolf
Health It Strategist, Kindred Healthcare
Co-Chair Health It Policy Committee, Certification & Adoption WG

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Office of the National Coordinator for Health IT

- Principal federal office charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information
- Authorized to develop programs "for voluntary certification of Health IT"
- Issues criteria for electronic health records used in Medicare and Medicaid EHR Incentive Program (Meaningful Use)

 89

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Voluntary Certification: Potential Opportunities in Behavioral Health

- Improved Care Continuum: evaluating potential certification of healthcare settings outside Meaningful Use program
- Support health care providers with health information needs
- Increasing interoperability – extended to new settings provides opportunities for better care, reduced cost

 90

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What we have heard

- Listening Sessions
- Stakeholder Engagement
- Health Information Exchange RFI
- Health IT Advisory Committees

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Certification Principles

- Leverage the existing certification program
- Voluntary
- Modular
- Interoperability (exchange and use across organizations)
- Privacy and Security (with enhancements)
- Setting-specific needs
  (assessments, code sets, group documentation)
- Alignment across state and federal programs
- Minimum burden
- Limited funding
- Very heterogeneous provider group

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Overview of Recommendations

For ALL Providers
- Transition of Care
- Privacy and Security
- Enhanced Privacy and Security (Data Segmentation/Consent Management)

LTPAC Setting-Specific
- Patient Assessments
- Survey and Certification

BH Setting-Specific
- Patient Assessments
- Enhanced Privacy and Security

For some LTPAC and BH Providers
- Clinical Reconciliation
- Clinical Health Information
- Labs/Imaging
- Medication-related
- CPOE
- Clinical Decision Support
- Quality Measures
- Patient Engagement
- Advance Care Planning
- Data Portability
- Public Health - Transmission to Immunization Registries

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Glide path for ***Senders*** of 42 CFR Part 2-Protected Data (***Part 2 Providers***)

Level	Status	Description
0	Current State	Sender cannot send patient information electronically without some technical capability to indicate information is subject to restrictions on re-disclosure consistent with Part 2. Sender also has to have confidence that receiver can properly handle electronically sent Part 2-covered data.
1	Document-Level Sequester	With authorization from the patient, sender EHR can send CCDA tagged as restricted and subject to Part 2 restrictions on re-disclosure.

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Glide path for ***Recipients*** of Part 2-Protected Data

Level	Status	Description
0	Current State	Part 2-covered data is not provided electronically to general healthcare providers. The status quo remains to share Part 2-covered data via paper, fax, etc.
1	Document-Level Sequester	Recipient EHR can receive and automatically recognize documents from Part 2 providers, but the document is sequestered from other EHR data. A recipient provider using DS4P would have the capability to view the restricted CCDA (or data element), but the CCDA or data cannot be automatically parsed/consumed/inter-digitated into the EHR. Document level tagging can help prevent re-disclosure.
2	Local Use Only Solution	Recipient EHR can parse and extract data from structured documents from Part 2 providers for use in local CDS and quality reporting engines, but data elements must be tagged and/or restricted to help prevent re-disclosure to other legal entities through manual or automated reporting or interfaces. This would allow the data to be used locally for CDS but would not require complicated re-disclosure logic for the EHR vendor (i.e. Processes around re-disclosure are not well-defined).
3	EHRs for General Use and Sharing Advanced Metadata and Re-disclosure*	Recipient EHR can consume patient authorization for re-disclosure from Part 2 provider and act on such authorizations at a data-level. At a minimum, the recipient EHR would need to make the user aware of whether additional Part 2 consent is required before re-disclosing any particular data element to another legal entity, and allow recording of patient authorization for re-disclosure at the data-level. Processes for re-disclosure are well-defined.

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Behavioral Health EHRs - What Vendors Need To Know – **Privacy/Security**

Zebulon Taintor, MD, DLFPA
Adjunct Professor Psychiatry, NYU SOM
June 27, 2014

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Different Roles and Interests

- Privacy - what patients want, ANYTHING can be sensitive
- Confidentiality - responsibility of clinician
- Security - you provide for clinician policy and operation, insuring against patient surprise
- Tiger Team basic principles

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What's Lost

- Financial data
- Health information (protected)
- Identity
  - Patient: diagnosis, hospitalizations, medications, words– anything to get at your patient: fitness, custody, employment, tenancy, etc.
  - Provider: NPI, Rx: eRx & pads, order forms

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How Much Is Lost?

- HHS web site: Office of Civil Rights: http://www.hhs.gov/ocr/privacy/index.html responsible since 2003
- Reported Breaches since 2009: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/breachtool.html

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Worse With More Connections

- Storage on mobile devices has shown a year-over-year increase in breaches involving more than 500 individuals: they are easily stolen and often less encrypted.
- Use of an unsecured wi-fi network can lead to undetected installation of programs that capture every key stroke of the device and eventually lead to capture of all data in the computer and its connections. Cloud computing and file-sharing devices are hard to secure.

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Prevention/Reduction

- What you can do:
  - Provide for granularity (segmented data), managed by patient/clinician
  - Do drills, tests, cyber assaults
  - Real time checks on unauthorized access by whom for what, prompt warnings to clinicians, patients
- Full presentation available from taintz01@nyumc.org

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Health Information Exchanges: Challenges

Steve Daviss, MD, DFAPA
Clinical Assistant Professor, Univ of Maryland SOM
Chair, APA Committee on Mental Health IT
Pres, Fuse Health Strategies; CMIO, M3 Information
June 27, 2014 ◆ steve@fusehealth.org ◆ @HITshrink

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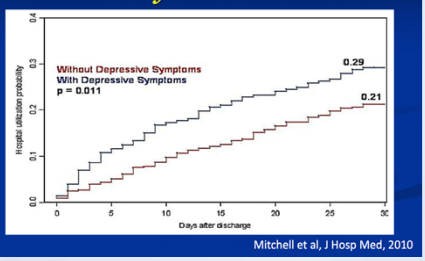
Depression Increases Risk of 30-Day Re-Admission



Mitchell et al, J Hosp Med, 2010

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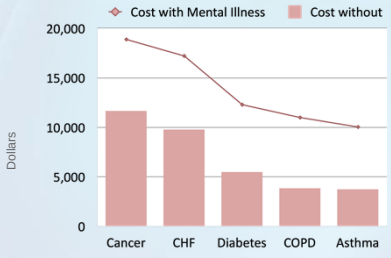
Increased costs of chronic medical conditions when mental illness co-exists



Source: Cartesian Solutions, consolidated health claims data

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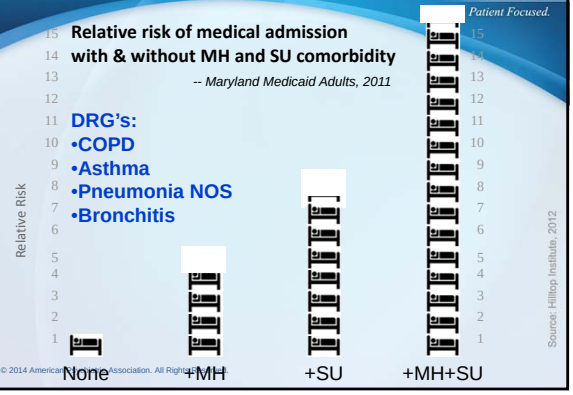
Relative risk of medical admission with & without MH and SU comorbidity

-- Maryland Medicaid Adults, 2011

DRG's:
- **COPD**
- **Asthma**
- **Pneumonia NOS**
- **Bronchitis**



Source: Hilltop Institute, 2012

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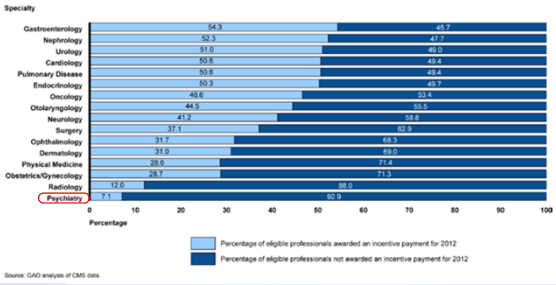
Figure 9: Percentage of Specialty Practice Physicians Who Were Awarded a Medicare EHR Incentive Payment for 2012, by Selected Specialty



Source: GAO analysis of CMS data.

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Incentives not relevant

- MH clinics not eligible, few docs
- few eligible for MA; limited MC participation
- some MU difficult
- RECs for PCPs only
- few EHRs have relevant functionality for BH
- 85% of psychiatrists are solo

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Unintended Consequences

- increased stigma
- trust: patients avoiding care due to fear of sensitive info "getting out there"
- being "off the grid" as a marketing advantage for clinicians
- pushing clinicians into early retirement

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What is needed?

- granular consent based on:
  - type of data
  - source of data
- consumer access to audit data
  - who saw what?
- "Give me my damn data!"
- open standards
- interoperability

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SAMHSA DS4P

- Substance Abuse and Mental Health Services Administration
- Data Segmentation for Privacy
  http://wiki.siframework.org/Data+Segmentation+for+Privacy+Homepage
- HL7 Standard
- Pilots:
  - VA/SAMHSA
  - SATVA
  - Netsmart
  - Jericho – UT/Austin
  - GNOHIE
  - Montogomery County, MD

 110

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Bottom line

Interoperable consent management architecture is needed to increase patient trust and decrease opt-outs.

Usability and privacy features must be considered to increase use by behavioral health providers.

Robust integration of behavioral health will reduce costs and improve quality. EHR vendors who get this right will win.

 111

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CMHIT - Contacts

Committee meets by teleconference 2nd Wednesday 6:00pm

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Terminologies Governmental Reporting

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APA Practice Guidelines Medical Editor
Steve Eichner
HIT Policy Manager, Texas Dept. of State Health Services

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Integrating DSM-5 into EHRs

- DSM-5 released in May 2013
  - Required over a decade of planning and development
- Elimination of multi-axial diagnostic systems facilitates use in traditional diagnosis/problem list software architecture
- Cross-cutting measures are comparable to other types of rating scales in EHR requirements
- Transitioning from DSM-IV, in part, dependent upon:
  - Acceptance of new terminology by insurers and others
  - Availability of DSM-5 terminology in EHRs and practice management systems

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Licensing DSM-5 for use in EHRs

- Directly through American Psychiatric Publishing
  - Submit licensing requests on-line and complete sections I, V, and VI at the following site: http://www.appi.org/CustomerService/Pages/Permissions.aspx
  - Contact Cecilia Stoute, Rights Manager for American Psychiatric Publishing at 703-907-8547 or cstoute@psych.org for questions
- Other Companies That License DSM-5:
  - Health Language
    - Contact: 720-940-2901, healthlanguageinfo@wolterskluwer.com
  - Intelligent Medical Objects, Inc
    - Contact Andrei Naeymi-Rad at 847-613-6646 or andrei@e-imo.com

 115

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DSM-5 and other Terminologies

- Organizational structure of DSM-5 topics reflects the anticipated structure of ICD-11
- DSM-5 is cross-walked to ICD-9-CM and to ICD-10-CM
  - Example: Panic disorder in DSM-5
    300.01 in ICD-9-CM
    F41.0 in ICD-10-CM
- SNOMED-CT has increasing importance as a terminology
  - Preliminary discussions are occurring with NLM about integration of DSM-5 with the Unified Medical Language System (UMLS) Meta-thesaurus and SNOMED-CT

 116

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Government Structures and Behavioral Health Care Delivery

A variety of government structures manage and deliver mental health and substance abuse services.

- In some states, mental health and substance abuse services are separate agencies.
- In some states, mental health and substance abuse are combined in single agencies.
- In some states, the department includes developmental disabilities.
- In some states, behavioral health is included in the public health department.
- Medicaid may be a separate agency.

 117

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Size of the Public Mental Health Delivery System

- Budget: $37.6 billion
- Population Served: 7.1 million people annually (50 states, 4 territories, and the District of Columbia)

Source: National Association of State Mental Health Program Directors (NASMHPD), http://www.nasmhpd.org/index.aspx, 6/20/2014)

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Clinical Workforce (Totals, 2012)

- 41,000 Psychiatrists
- 96,000 Psychologists
- 193,000 Clinical Social Workers
- 14,000 Psychiatric nurses
- 48,000 Substance Abuse Counselors
- 145,000 Counselors
- 62,000 Marriage and Family Therapists

Source: Data assembled from various sources by SAMHSA and published in *Behavioral Health, United States, 2012.*

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State Government Roles in Behavioral Health

- Regulator- States license facilities and providers
- Payer- States may pay contractors for the delivery of behavioral health services
  - Medicaid
  - Federal Mental Health/Substance Abuse Block Grants/ State General Revenue/Other funds
- Direct Provider
  - Outpatient Services Through Community Clinics
  - Inpatient Services Through State Psychiatric Hospitals

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Behavioral Health Data Reporting- Government Contractors

- State operated systems support reporting of contract management, administrative, and clinical data
- States often require use/submission of specified clinical assessment tools (may vary by state)
- Some states host web-based systems for manual data entry, others support automated exchange
- Reporting supports contract management, administrative oversight, and quality of care
- Summary (de-identified) data may be included in public reports documenting accountability

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Use of Standards in Government Reporting for Behavioral Healthcare

- Reporting requirements may exceed data in HIPAA standard transactions
- Limited national interoperability messaging standards
- Data feeds through states into national reporting framework, where appropriate
- Data is collected and utilized consistent with applicable state and federal law

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Government Involvement with HIT Delivering/Supporting Behavioral Healthcare

- Both custom-developed and Commercial-Off-the-Shelf (COTS) systems are utilized
- Some states provide services to support health information exchange within contracted provider networks
- There is general interest in connecting with more general-purpose HIEs, however there is some complexity due to particular data issues including:
  - Sufficient information for continuity of care for behavioral health may not be included in current CCDs
  - Parsing data to ensure compliance with legislation
  - Consent management issues such as such as 42 CFR 2

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Behavioral Health EHRs - What Vendors Need To Know
Concluding Remarks

Lori Simon, MD
June 27, 2014

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Purpose of Webinar

- Define the Market for Behavioral Health EHRs to help you better recognize the importance of supporting Behavioral Health and that doing so can be financially advantageous.
- Acquaint you with the projects currently being worked on that can help you optimally support Behavioral Health. (APA, AACAP, SAMHSA, HL7, ONC)
- Discuss the major issues that exist within the Behavioral Health field which impact the use of computer technology.

 125

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Next Steps

- Proceed with Requirements Consolidation Project
- Reach out to other Behavioral Health professional organizations.
- Develop structure for ongoing contact with vendors:
  - Webinars
  - In-Person Meetings
  - Contact at Professional Organization Conferences
  - Other Ideas (need your help)
  - Will develop plan for next vendor engagement(s) within 1 month.

 126

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Immediate Activities

- Complete Feedback Form – Link in Registration Confirmation (https://docs.google.com/forms/d/1-w8q7hKqOX0958iaA1uVF9t0ECSW6mR7diiqU4C4X8k/viewform?c=0&w=1&usp=mail_form_link)
- Answers to all questions not provided during webinar will be provided within 1 week.
- Copy of Slides, Recording of Webinar on APA's website within next 2 weeks (www.psych.org/EHR)

 127

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Thank You

- Presenters
  - Alan Axelson – APA MHIT Committee, AACAP
  - Dan Balog – APA MHIT Committee
  - Steve Daviss – APA MHIT Committee
  - Amy Helwig – ONC
  - Jim Kretz – SAMHSA, HL7
  - Ioana Singureanu – SAMHSA, HL7
  - Larry Wolf – Kindred Healthcare, ONC
  - Zebulon Taintor – APA MHIT Committee

 128

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Thank You

- Contributors
  - Laura Fochtmann - APA Practice Guidelines
  - Steve Eichner - Texas Department of State Health Services (DSHS)
  - Todd Peters - AACAP
- APA Staff
  - Lisa Greiner - Administrative Support
  - Bill Narrow - Acting Director Division of Research Acting Director Office of Quality Improvement and Psychiatric Services

 129

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Biggest Thank You

All of the attendees who took the time to participate in this webinar!!

We hope to see you again!!

130