

Behavioral Health Roundtable

Using Information Technology to Integrate Behavioral Health and Primary Care

Summary Report of Findings

September 2012

Prepared for: Office of Policy and Planning
Office of the National Coordinator for Health Information
Technology
U.S. Department of Health and Human Services

Prepared by: RTI International
Center for the Advancement of Health Information Technology

ONC greatly appreciates the contributions of the Substance Abuse and Mental Health Services Administration (SAMHSA) throughout the roundtable.

1. Introduction

The burden of behavioral health conditions (including mental illness and substance use disorders) in the United States remains great. Consider the prevalence and treatment of mental illness. By 2009, almost 20 percent of adults in the United States had suffered from a mental health condition at some point in their lives.¹ Mental illness is a source of significant comorbidity in the chronically ill, particularly for patients with diabetes or cardiovascular disease. Diabetes patients, for instance, are twice as likely to suffer from depression as the general population.² Mental illness is also associated with higher rates of substance abuse.³ In 2010, approximately 23 million people ages 12-64 reported symptoms of substance use disorders, while only 11 percent received treatment at a specialty facility.⁴ Moreover, a substantial volume of behavioral health care is delivered in primary care settings. General and internal medicine physicians cared for 34 percent of patients with a primary mental health diagnosis in 2008 alone.⁵ Given the burden of illness and the volume of behavioral health care delivered in primary care settings, better integration between behavioral health and primary care is needed.

Health information technology (health IT), including electronic health records (EHRs), personal health records (PHRs), health information exchange (HIE), mobile health, and other technologies that support health and wellness are key enablers of this integration. However, behavioral health clinicians currently have limited adoption of interoperable information systems. In a recent study, just over 20 percent of 505 behavioral health organizations surveyed indicated that they had fully adopted an EHR.⁶ Behavioral health organizations cited as barriers to EHR adoption concerns over initial productivity losses, lack of qualified IT and project management staff, provider resistance, and privacy laws.

2. Roundtable Overview

To help coordinate the adoption and use of health IT in integrating primary care and behavioral health, RTI International, under contract with the Office of the National Coordinator for Health Information Technology (ONC), held a day-long Behavioral Health IT Roundtable meeting. Hosted at the U.S. Department of Health and Human Services headquarters in Washington, DC

¹ Substance Abuse and Mental Health Services Administration (2012). *Mental Health, United States, 2010*. HHS Publication No. (SMA) 12-4681. Rockville, MD: Substance Abuse and Mental Health Services Administration.

² Egede, L. E., Zheng, D., & Simpson, K. (2002). Comorbid depression is associated with increased healthcare use and expenditures in individuals with diabetes. *Diabetes Care*, 25(3), 464-470.

³ Martins, S. & Gorelick, D. (2011). Conditional substance abuse and dependence by diagnosis of mood or anxiety disorder or schizophrenia in the US population. *Drug and Alcohol Dependence*, 119(1-2), 28-36.

⁴ Substance Abuse and Mental Health Services Administration (2011). *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings*. NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Rockville, MD: Substance Abuse and Mental Health Services Administration.

⁵ Centers for Disease Control and Prevention (2008). *National Ambulatory Medical Care Survey*.

⁶ The National Council (2012). *HIT Adoption and Readiness for Meaningful Use in Community Behavioral Health: Report on the 2012 National Council Survey*. National Council for Community Behavioral Healthcare.

on July 24, 2012, the roundtable included private and public-sector stakeholders with representatives from consumer, provider, payer, HIE, professional association, vendor, health IT certification organizations, and other federal agencies (**Appendix A**).

As part of its mission, ONC aims to coordinate the adoption and use of health IT to support broader objectives of integrating behavioral health and primary care. This roundtable was an important first step in developing a behavioral health IT strategy in support of this mission. ONC worked with participants during the roundtable to identify priority areas for using health IT to achieve better integration, and to discuss options for addressing these areas. As part of these discussions, ONC urged roundtable participants to consider providers who are both eligible and ineligible for financial incentives under the Medicare and Medicaid EHR Incentive Programs. In this regard, ONC was interested in having roundtable participants note how future stages of Meaningful Use could be used to support integration. ONC was also interested in roundtable participants' suggestions on how other areas of ONC activity—including innovation grants, standards development, and certification criteria—could further this integration.

ONC framed the roundtable discussions by listing prior recommendations for essential elements of care integration between behavioral health and primary care settings: a mechanism for bidirectional communications with primary care providers; a determination of what information is most essential to share; and adoption of appropriate confidentiality and consent protocols.⁷ As ONC already had existing efforts aimed at confidentiality and consent, they urged roundtable stakeholders to consider the first two of these recommendations—bidirectional communication and essential information sharing—as they formulated priorities and discussed approaches to addressing them.

A summary of the results of roundtable discussions is detailed in the following sections. The complete roundtable agenda, including discussion questions, is provided in **Appendix B**. Participants offered a wide range of input to ONC, with focus areas, recommendations for action, and suggestions for completing these actions surfacing throughout the day. The roundtable provided some clear directions for ONC and roundtable attendees to pursue. In short, it served as a forum for formative discussions about directions ONC and behavioral health stakeholders should take in using health IT to support care integration.

3. Adoption of Health IT by Behavioral Health Providers

Results from the National Council's Behavioral Health Organizations' Adoption of Health IT and Readiness for Meaningful Use survey, presented at the roundtable, showed low rates of EHR

⁷ Parks, J., Pollack, D., Bartels, S. (Eds); Mauer B. (2005). *Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities*. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council.

adoption among behavioral health providers.⁸ Implementation of the Mental Health Parity and Addiction Equity Act and the Patient Protection and Affordable Care Act (ACA) will increase access to behavioral health care for millions of patients and emphasize integrated health care. Adoption of health IT is critical to support care coordination, patient engagement and access to care, and ultimately health reform. Participants discussed two key challenges to adoption: limited financial resources and a lack of trained health IT professionals.

Aside from the relative absence of EHR financial incentives for behavioral health providers, participants voiced concerns that smaller behavioral health providers may be overburdened by adopting these systems or priced out of the EHR market; these smaller providers often lack the resources to implement and maintain an EHR system. However, participants noted that cloud-based EHR solutions might provide a cost-effective option for smaller providers. Participants also cited workforce issues: the lack of trained professionals skilled in implementation, data standards, and interoperability hampers adoption and use of health IT and HIE.

EHR adoption by behavioral health providers is a necessary first step in using health IT to integrate behavioral health and primary care. As one participant noted, behavioral health providers' access to funding and resources is a major bottleneck to adoption. Thus, many roundtable participant recommendations focused on aspects of this issue.

Participant Recommendations

Provide clear strategies to increase EHR adoption among behavioral health providers.

Many roundtable participants suggested that ONC had an important role in helping determine how behavioral health providers could access financial resources to support EHR adoption. Although participants understood that federal agencies could not direct Meaningful Use financial incentives to these providers unless authorized by Congress, some suggested that ONC could help identify and establish partnerships between providers—encouraging the sharing of resources to support care coordination through health IT (e.g., using the Health Center Control Networks, or HCCN, to create economies of scale for consulting, software, training, maintenance contracts, and technical assistance). Other participants stressed the need for vendors to develop low-cost systems, particularly for smaller providers.

Provide technical assistance to behavioral health providers who adopt EHRs. Many behavioral health providers who adopt EHRs lack dedicated IT staff or resources. Technical assistance is incredibly valuable to providers who are not a part of large health systems and do not have dedicated IT staff. Regional Extension Centers can be valuable resources for the

⁸ The National Council (2012). *HIT Adoption and Readiness for Meaningful Use in Community Behavioral Health: Report on the 2012 National Council Survey*. National Council for Community Behavioral Healthcare.

implementation of behavioral health-specific workflows and other assistance small practices may need.

Develop a certification for behavioral health EHRs. Behavioral health providers struggle with the selection of an EHR system that will meet their unique needs. Many providers are delaying the adoption of EHRs for fear that existing systems may become obsolete in this rapidly changing health IT environment. Behavioral health providers often exist at subsistence level and would not recover from the loss of such a large capital investment. Many of the certification criteria in the EHR certification program are not relevant to behavioral health (e.g., transmission to immunization registries). Implementation of unneeded functionality may be a waste of resources in a severely under-resourced field. Participants suggested that ONC develop a core certification program applied across all specialties that can be augmented by a behavioral health-specific certification program, which the behavioral health community could develop.

Use challenge grants to increase access to care. Participants also noted the prevalence of workforce shortages of behavioral health providers in areas across the country, especially in rural areas. These shortages are expected to grow with the implementation of parity regulations and the expansion of Medicaid in 2014. Use of challenge grants or other mechanisms to bring services to underserved populations through health IT tools, such as tele-mental health, could play an important role in addressing this issue.

4. Areas of Focus for Care Integration Using Health IT

In a background brief produced separately and shared with participants prior to this roundtable, ONC suggested three areas in which health IT will be key to better integrate behavioral health and primary care: care coordination, patient engagement, and medication management. Initial discussions validated these important areas of focus, and roundtable attendees detailed issues and challenges related to each. Participants also suggested additional priorities—some of which ONC could influence directly, and others requiring effort from other federal agencies and lawmakers. The following sections summarize these areas.

4.1 Care Coordination

Integration of behavioral health and primary care has been a focus area for federal agencies, behavioral health professional associations, and other stakeholders for almost a decade. The ACA includes provisions for initiatives such as person-centered health homes and primary and behavioral health integration grants. These initiatives have renewed the focus on the care coordination between primary care and behavioral health providers.

Health care providers routinely, but not always, exchange information about patients they share. Through electronic HIE, the ability of a patient's care team to share data during transitions of care will be more efficient and standardized. However, both patient and provider concerns about the appropriate storage and maintenance of these electronic data are preventing the widespread use of HIE between primary care and behavioral health providers. The standardization of a Continuity of Care Document (CCD) in electronic format promises to allow a more efficient, effective, and complete transition of care information between treating providers. The Substance Abuse and Mental Health Services Administration (SAMHSA) has been leading efforts to develop standards and recommendations about what data to include in a CCD disclosed by a behavioral health provider through the international standards development organization Health Level 7 (HL7).

During the roundtable participants emphasized the need for care coordination to improve patient outcomes and lower costs, and shared anecdotes on the potential impact of care coordination relative to behavioral health patients. In addition to caring for individual patients, roundtable participants spoke about how EHRs and health IT tools support collaboration by primary care and behavioral health providers, enabling care teams to track patient progress over time and to identify patients with poor outcomes for intervention. Participant recommendations in this category included enhancements to EHRs as well as enhancements of clinical data summaries and continued support for HIE capabilities.

Participant Recommendations

Develop best practice guidelines on the use of health IT to support integration of behavioral health and primary care. Roundtable participants highlighted the need to identify best practices of care coordination using health IT. Participants stressed the need to learn from those organizations that have already implemented care coordination practices and tools. Participants mentioned potential sources including Federally Qualified Health Centers (FQHCs) and patient-centered medical home tools developed by the National Center for Quality Assurance. Partnering with other federal agencies, such as the Health Resources and Services Administration and the Centers for Medicare and Medicaid Services (CMS) as well as soliciting feedback from the field can provide insight into best practices and potential challenges of coordinated care relative to behavioral health. Participants highlighted a number of areas that would be useful to address: how to comply with federal health information privacy laws, how to determine the chain of responsibility for following up with patients (i.e., when a patient does not make it to a referral appointment), sharing sensitive information through dashboards, storage and access to psychotherapy notes, referral management, liability issues, etc.

Educate primary care stakeholders about federal behavioral health privacy regulations. Informing primary care providers and organizations on the proper protocols for receiving,

storing, and managing behavioral health data electronically will also improve care coordination. Compliance with the Federal Confidentiality of Alcohol and Drug Abuse Patient Records regulations—or 42 CFR Part 2, which specifies the conditions and requirements for disclosure of patient information regarding substance abuse treatment programs—is a significant concern to the behavioral health community. This regulation requires patient consent to share substance abuse treatment information. In addition, these regulations prohibit re-disclosure of this information without consent. Currently, most primary care EHR systems do not have the capacity to manage consents or to control the re-disclosure of select types of information. In addition, most primary care providers and technology vendors are unaware of these regulations and the legal obligations of receiving substance abuse treatment data. Participants stressed the need to educate this community on the requirements and to work with them to develop the necessary functionality to manage consents and re-disclosure of substance abuse data.

Provide explicit instructions on how HIEs should handle behavioral health-related data. In a related discussion one panelist remarked about how the chief information officer of one HIE stated that its policy for receiving and sharing 42 CFR Part 2 data was “to run away from it.” This panelist suggested that the EHR vendor community needed explicit instructions and clear definitions on how to treat Part 2 data, and would welcome clarification similar to certification criteria for behavioral health data. It was also noted that the HIEs could be used to support a community record, including data from criminal justice, housing and urban development, and other social support systems. Guidance on privacy and other policy issues related to the development of a community record would be useful.

It was further noted that health information privacy is already a prominent issue of high priority to both ONC and SAMHSA. Within the Standards & Interoperability Framework, ONC has a Data Segmentation for Privacy Initiative through which SAMHSA and the Veterans Administration are piloting approaches to data segmentation and granular consent management that will help solve these issues. In communications following the roundtable, some behavioral health providers advocated for patients’ treatment goals to be available to all care team members, when exchanged, without any “break the glass provisions.”

Include Clinical Decision Support (CDS) for behavioral health screening and treatment in EHRs. Integrated care requires the use of standard behavioral health screening and assessment tools, delivery of treatments, and evaluation of progress across care settings. Accordingly, roundtable participants also stressed the need for CDS related to behavioral health. Electronic screening tools are needed in primary care settings to initially identify a behavioral health risk or condition, and are used in behavioral health settings to track patient’s progress and outcomes. Participants suggested promoting the development of CDS tools to deliver primary care in behavioral health settings and to deliver behavioral health care in primary care settings. They suggested that alignment of these tools could help to facilitate care coordination and “warm

handoffs” when referrals are needed. In addition, participants highlighted the need for CDS focusing on medication-assisted treatment of behavioral health disorders. CDS needs to include treatment recommendations based upon screening results, providing clinicians with options for treatment of substance abuse and mental health in a primary care setting and recommendations about when to refer to specialty care.

Promote the development of standards for behavioral health assessment tools. As part of this recommendation, participants also debated issues of screening tool standardization. Many standard assessment tools exist for a given purpose (e.g., screening for alcohol use). Additional guidance and standards for the selection of validated tools, the incorporation of those tools in the EHR, and the coding and exchange of related data would be useful. However, while standards may be necessary to successfully exchange data, mandating the use of a specific screening instrument may limit providers’ abilities to select tools that they prefer and to develop new, innovative approaches to screening. Participants debated and generally agreed on one potential solution: develop a standard data schema for screening and assessment tools. This solution may include developing standards for the endorsement of validated tools and developing standard processes for calibrating tools to a single standard scale. This approach could make the data from screening tools interoperable, while preserving provider choice and flexibility to select instruments that best meet care needs as the field evolves. One participant noted that a significant amount of work assessing and developing reliable, valid screening instruments had already been completed, and was available through the Agency for Healthcare Research and Quality’s Web site (<http://www.ahrq.gov/research/mentalix.htm>).

Include clinical quality measures in Meaningful Use for behavioral health screening and treatment that complement the use of CDS. Another recommendation was to expand the use of performance measures for behavioral health screening in the Meaningful Use program, i.e., include performance measures about appropriate use of behavioral health risk assessments, as specified by professional societies or other organizations such as the National Quality Forum. In tandem with CDS tools, these measures optimize care coordination by ensuring appropriate behavioral health screening and treatment are received, particularly for patients with comorbid chronic conditions.

Enhance the Continuity of Care Document. Regarding structured data exchange, participants also discussed whether or not the CCD standard, as currently specified, adequately supports care coordination between behavioral health and primary care providers. Participants noted how data elements important to behavioral health, such as risk of violence, risk of suicide, history of substance use, housing status, criminal justice and others, were not contained in current CCD specifications. SAMHSA is leading an effort through HL7 to update the standards for the CCD to include additional behavioral health information. Some participants advocated the creation of modest constraints for behavioral health data elements in the CCD—defining a core set but

making additional data elements optional. Others noted that primary care providers often start over with diagnostics when they receive incomplete records. Behavioral health EHRs track Diagnosis Axis 1-5 while the CCD includes diagnosis in the “problems” area. Behavioral health providers track problems related to the diagnosis or possibly not related to a diagnosis—for example, a patient with diabetes who does not take his or her medications regularly. The terminology of problems/diagnosis must be reconciled to make the current CCD useful to behavioral health providers. Behavioral health providers also noted that a field simply for progress notes was insufficient. Only the immediate provider may review that content; however, specific fields related to treatment plans, goals, and referrals may facilitate integration. Additionally, the inclusion of specific key words related to behavioral health in certified EHR capabilities may assist in documentation.

Ensure EHRs can support development and sharing of a Wellness Recovery Action Plan (WRAP). As an effective tool for patient engagement, some participants suggested including WRAP capabilities in EHRs and other certified health information technologies. WRAP plans include a patient’s own priorities for managing his or her behavioral health conditions. When exchanged with members of a patient’s care team, these plans are one important means to shared care and more complete information about patient’s goals, therapies, progress, and challenges.

Develop standards for referral management. Patients with behavioral health care needs may not always proactively seek care. Health IT systems can reduce the barriers to arranging care and help prevent patients from falling through the cracks. Health IT systems could be used to facilitate scheduling referral appointments in real time, to remind patients of upcoming appointments, to send alerts if severely ill patients miss appointments or do not refill critical prescriptions, to automate information sharing between the referring provider and the behavioral health provider, etc. Development of standards for these processes could be very valuable for the behavioral health field as well as for other chronic conditions.

4.2 Patient Engagement

Use of the term *patient engagement* reflects a cultural shift towards patient-centeredness in health care, where patients are seen as equal partners in their care and respected as experts in their own health experience. As part of patient-centered care, patient engagement is the active sharing of information and decisionmaking with patients to help them understand diagnoses and treatment options, select those options that best meet their goals, and manage their self-care. An important cornerstone of patient engagement is patient-provider communication; the bidirectional sharing of information and dialog between patient and provider facilitated patients playing an active role in their own care. Strong patient-provider communication has been associated with improved patient comprehension and retention of information, increased

patient satisfaction, increased compliance, reduced anxiety, and improved treatment outcomes.^{9,10,11}

Participant Recommendations

Educate behavioral health patients on treatment and privacy decisions using clear language. Participants agreed that patient engagement was an important focus area and noted that patient engagement should also include family and caregivers. To engage patients, stakeholders noted that efforts are needed to educate patients about their privacy rights and the implications of sharing information. To successfully educate patients on these matters, clear and simple terms may be needed to translate complicated medical terminology. Patient advocates highlighted the need to show patients clear examples that will help them understand to what they are consenting (e.g., sample CCDs and discharge summaries). Participants stressed that the patient should remain at the center of care decisions.

Provide guidance on the impact of and practices for incorporating patient-generated health data into EHRs. Roundtable participants also discussed patient-generated health data (PGHD), which includes information patients share about their symptoms, health behaviors, treatment adherence and side effects, physiological states, and disease progression outside of a clinical setting. Some participants noted how their organizations had successfully implemented patient-centered tools, such as medication symptom trackers and patient journals; however, others noted questions about liability in this context. Incorporating PGHD into an EHR may be beneficial, but what are the legal risks related to reviewing and acting (or not acting) upon this data? For example, if a patient uses a mobile health (mHealth) tool to share information with a provider and indicates a suicide risk, the provider may be liable if the patient then acts upon this indication before the provider can intervene. While the potential benefits of this data were appealing—more complete medication lists and better tracking of symptoms and treatment side effects—participants agreed that behavioral health and primary care providers would benefit from receiving guidance from ONC and other federal agencies about the issues involved in PGHD and in practices for its use in care planning and delivery.

Promote the development of health IT systems to facilitate peer support. Peer support services are a key component of behavioral health services and person-centered recovery. Participants suggested that development of systems that can support information sharing with members of one's recovery or support team that are not a part of the medical establishment has great potential to advance behavioral health outcomes.

⁹ Ley, P. (1988). *Communicating with Patients*. London: Chapman and Hall Press.

¹⁰ Newton, J. T. (1995). Dentist/patient communication: A review. *Dental Update*, 22, 118-122.

¹¹ Witt, E. & Bartsch, A. (1996). Effects of information giving and communication during orthodontic consultation and treatment. Part 3: Optimized orthodontist-patient communication. *Journal of Orofacial Orthopedics*, 57, 154-167.

4.3 Medication Management, Adherence, and Abuse

Medication management refers to the standards of care that ensure patients' medications are assessed to determine their appropriateness, effectiveness, and safety for patients' medical conditions. Medication regimens increase in complexity as comorbidities increase, requiring comprehensive review and reconciliation. Medication management includes an individualized care plan in which patients understand and actively participate to optimize treatment outcomes.¹² Medication nonadherence is a significant problem in patients with behavioral health disorders.^{13,14,15} Promoting adherence may greatly improve outcomes.

Participants indicated this topic area should be broadened to include treatment adherence, as nonpharmacological treatments are important to behavioral health outcomes. Discussions also centered on privacy laws and regulations that can present barriers to sharing behavioral health treatment information, including medications. These laws and regulations, while important, can create difficulty when selecting medications or transitioning between care providers and care settings. Overcoming barriers to information sharing and coordination of care will be critical to improve safety and efficacy of care for patients with behavioral health disorders.

4.4 Reporting System Fragmentation and Duplication

During the roundtable discussion, stakeholders also mentioned the burden of multiple reporting systems as a significant focus area related to care integration. Roundtable participants discussed the onerous administrative tasks many behavioral health providers face by having to report the same information to different federal, state, and local entities using different systems. For example, some providers may be required to report duplicate patient information regarding child welfare, developmental disabilities, and HIV interventions to several federal and state health agencies as well as payers for reimbursement. This requirement is especially burdensome for small providers and significantly increases the cost of care delivery. Stakeholders urged ONC to collaborate with other federal agencies to use health IT to facilitate the streamlining and standardization of duplicate reporting. The current standards can be a launch point for standardizing data collection by federal and state agencies.

¹² Patient-Centered Primary Care Collaborative (2010). *The patient-centered medical home: Integrating comprehensive medication management to optimize patient outcomes*.

¹³ Miasso, A., Monteschi, M., & Giaccherio, K. (2009). Bipolar affective disorder: Medication adherence and satisfaction with treatment and guidance by the health team in a mental health service. *Revista Latino-Americana de Enfermagem*, 17(4), 548-556

¹⁴ Johnson, F., Ozdemir, S., Manjunath, R., Hauber, A., Burch, S. & Thompson, T. (2007). Factors that affect adherence to bipolar disorder treatments: A stated-preference approach. *Medical Care*, 45(6), 545-552.

¹⁵ Fleck, D., Keck, P., Corey, K. & Strakowski, S. (2005). Factors associated with medication adherence in African Americans and white patients with bipolar disorder. *Journal of Clinical Psychiatry*, 66(5), 646-652.

5. Summary of Participant Recommendations

Throughout the discussions, as described previously, participants offered guidance and suggestions to ONC and their federal partners about actions to advance behavioral health IT. Some recommendations were specific to a given area, such as care coordination or adoption, while others concerned multiple areas. To facilitate ONC action, participant recommendations were grouped into three areas that align with ONC’s mission and areas of authority: health IT capabilities and standards, adoption support, and education. Recommendations in each area are summarized in **Table 1**.

Table 1. Summary of Recommendations from Roundtable Participants

| Topic | General Recommendations |
|--------------------------------------|--|
| Health IT Capabilities and Standards | <ul style="list-style-type: none"> • Include CDS for behavioral health screening and treatment in EHRs. • Include clinical quality measures in Meaningful Use that complement the use of CDS for screening and treatment. • Provide explicit guidance on how primary care (eligible provider) EHRs should handle behavioral health-related data. • Engage behavioral health providers in defining additional data elements needed in CCD to support behavioral health. • Continue endorsement of Direct for behavioral health providers who have not adopted EHRs. • Ensure EHRs can support development and sharing of a WRAP. • Develop standards for referral management. • Promote the development of standards for behavioral health assessment tools. • Incorporate discrete fields into certified EHR technologies for behavioral health data. |
| Adoption Support | <ul style="list-style-type: none"> • Provide clear strategies to increase EHR adoption among behavioral health providers, including means to accessing financial and technical resources. Encourage vendors to develop low-cost systems. • Use prior health IT adoption experiences to inform development for behavioral health and primary care integration use cases. • Provide technical assistance to behavioral health providers who adopt EHRs. • Develop a certification for behavioral health EHRs. • Use challenge grants to improve access to care. |
| Education | <ul style="list-style-type: none"> • Identify and disseminate best practices from organizations that have successfully integrated behavioral health and primary care. • Support provider education for proper handling of behavioral health data, especially in relation to substance abuse data and consent to disclose and re-disclose data. • Provide guidance on the impact of and practices for incorporating patient-generated health data into EHRs. • Educate behavioral health patients on treatment and privacy decisions using clear language. • Promote the development of health IT systems to facilitate peer support. |

6. Conclusions and Next Steps

The roundtable discussion validated the importance of ONC's three topic areas and identified additional areas. Throughout the day-long roundtable, participants offered suggestions that addressed issues in many of these areas. Many topics and recommendations align with, or could be incorporated into, existing ONC efforts including the Standards & Interoperability Framework and development of Stage 3 Meaningful Use recommendations and EHR certification criteria. The recommendations outlined may also coincide with other federal initiatives regarding integrated care (including SAMHSA's *Primary Care and Behavioral Healthcare Integration Program*) and patient-centered health homes (such as CMS's *Medicaid State Option to Provide Health Homes for Enrollees with Chronic Conditions*). The evolving landscape of health care delivery underscores the importance of public-private partnerships and collaboration of federal initiatives to address the disparate adoption and use of health IT in behavioral health care settings. As a next step, ONC will use these areas and recommendations as one important source of input to coordinate adoption and use of health IT to support behavioral health and primary care integration.

The high levels of engagement and thoughtful contributions by participants representing a broad range of organizations and stakeholders underscored the importance of the role of health IT in integrating behavioral health and primary care to the behavioral health community at large. Prioritizing the focus areas identified during the roundtable for action, and then supporting these actions, will require continued participation by members of this community. Other health care constituencies like those in long-term and post-acute care (LTPAC) settings have developed coordinated efforts across public and private sectors to advance health IT issues. For instance, the LTPAC HIT Collaborative engages a range of LTPAC stakeholders in identifying issues in the use of health IT to improve long-term care quality and safety; in developing plans (i.e., roadmaps) that prioritize action; and then in supporting coordinated efforts to enact these plans. Similar coordinated efforts could have a powerful impact on the behavioral health field. As lead coordinator for the nation's efforts to adopt and use health IT to achieve important quality, safety and efficiency goals, ONC could work with the behavioral health community in identifying or forming such collaboration, and then serve to facilitate the federal government's participation in this collaboration.

Appendix A. Behavioral Health IT Roundtable Participants

Providers

| | |
|---|---|
| Steven Daviss, MD Chair, Committee on Electronic Health Records | American Psychiatric Association |
| Michael Gloth, MD Chief Medical Officer Associate Professor of Medicine | Moorings Park Healthy Living Division of Geriatric Medicine & Gerontology Johns Hopkins University School of Medicine |

Vendors

| | |
|--|---|
| Mike Morris Chief Executive Officer | Anasazi Software, Inc. Leader, Software and Technology Vendors Association, Behavioral Health Interoperability Workgroup |
| Kevin Scalia Executive Vice President of Corporate Development | NetSmart Technologies, Inc. |
| Fran Loshin-Turso President | Defran Systems |
| David Klements President and Chief Executive Officer | Qualifacts Systems, Inc. |

HIE Expertise

| | |
|--|--|
| Julia Costich, JD, PhD Behavioral Health Data Exchange Representative | University of Kentucky College of Public Health |
| Karen Chrisman, JD Staff Attorney | Governor's Office of Electronic Health Information Kentucky Health Information Exchange |
| Gary Parker IT Project Director | Alabama's One Health Record Alabama Medicaid Agency |

Consumer Representatives

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| Paul Cumming National Outreach Advocate | Network of Care |
| Carol Coussons de Reyes, MS Director of Consumer Affairs | Nebraska Department of Behavioral Health |

Foundations and Innovators

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|---|--|
| Lynn Bufka, PhD Assistant Executive Director | American Psychological Association |
| Michael Lardiere, LCSW Vice President, Health IT and Strategic Development | The National Council for Community Behavioral Healthcare (The National Council) |
| Joel Miller, MSED Senior Director, Policy and Healthcare Reform | National Association of State Mental Health Program Directors |
| Rick Harwood Director, Research and Program Applications | National Association of State Alcohol and Drug Abuse Directors, Inc. |
| Steven Rosenberg President | Community Oriented Correctional Health Services |
| Roy La Croix, MBA Chief Executive Officer | PTSO of Washington |
| Tricia Roddy Director | Office of Planning, Healthcare Financing Maryland Department of Health & Mental Hygiene |

Standards

| | |
|---|---------------------------------------|
| Daniel Crough, MHSM Data Architect | Arizona Department of Health Services |
| Madan Gopal, PhD Health IT Architect and Project Manager | Arizona Department of Health Services |

Certifying Body for Certified EHR Technologies and Behavioral Health

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| Naomi Levinthal, MA, MS Certification Manager | Certification Commission for Health Information Technology |
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Federal Advisory Committee Member(s)

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|------------------------------------|--------------------|
| Larry Wolf Health IT Strategist | Kindred Healthcare |
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Federal Partners

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| Maureen Boyle, PhD Lead Public Health Advisor, Health IT | Center for Substance Abuse Treatment Substance Abuse and Mental Health Services Administration (SAMHSA) |
| Ken Salyards HIT Special Assistant | SAMHSA/ HL7 |
| June Sivili, MA Senior Adviser | Office of Demand Reduction White House Office of National Drug Control Policy |
| Betty Tai, PhD Director | Clinical Trials Network National Institute on Drug Abuse (NIDA) |
| Vivian Faden, PhD Director, Office of Science Policy and Communications Associate Director, Behavioral Research | National Institute on Alcohol Abuse and Alcoholism |
| Udi Ghitza, PhD Health Scientist Administrator | Center for Clinical Trials Network NIDA |
| Arun Natarajan, MS Health Insurance Analyst | Centers for Medicare and Medicaid Services (CMS) Division of Long-Term Services and Supports |

ONC Representatives

| | |
|----------------------|---|
| Jodi Daniel, JD, MPH | Director, Office of Policy and Planning |
| Kate Tipping, JD | Policy Analyst, Office of Policy and Planning |
| David Muntz, MBA | Principal Deputy |
| Scott Weinstein, JD | Presidential Management Fellow Office of Chief Privacy Officer |

RTI International

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|---------------------------|---|
| Don Mon, PhD | Senior Director and Director of Standards and Interoperability, CAHIT |
| Doug Johnston, MTS | Director, Health IT Policy CAHIT |
| Shellery Cunningham, MSPH | Health IT Analyst CAHIT |

Appendix B. Roundtable Agenda



Behavioral Health IT Roundtable

Humphrey Building
200 Independence Avenue
Washington, DC
July 24, 2012

9:00am – 4:00pm Room 425A

AGENDA

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|--|--------------------------------------|----------------------|
| 1. Welcome & Opening Remarks | Jodi Daniel Maureen Boyle | 9:00 – 9:30 |
| a. Housekeeping & Introductions | | |
| b. Project Motivations | | |
| c. Objectives and Agenda | | |
| 2. Framing the Discussion | Kate Tipping | 9:30 – 10:00 |
| a. Overview of National Council Survey Michael Lardiere | | |
| b. BH Data Segmentation for Privacy Scott Weinstein | | |
| BREAK | | 10:00 – 10:15 |
| 3. Integrating BH and Primary Care | Jodi Daniel | 10:15 – 10:45 |
| Identifying Priorities: | | |
| a. Care Coordination | | |
| b. Patient Engagement | | |

- **How do the proposed Stage 2 Meaningful Use criteria, certification criteria, and related standards align with the range of behavioral health and primary care providers' needs?**
 - Which of these criteria and standards are relevant to behavioral health providers – and primary care providers who treat behavioral health patients – and which are not?

- **What else might behavioral health providers need that is not covered by current criteria and standards?**
 - Which proposed Stage 2 measures would need to be modified and how?
 - What new measures might be proposed for Stage 3?
 - What are the different needs based on setting (mental health, substance abuse treatment facility, criminal justice)?
 - Is there a need for separate certification for behavioral health EHRs?

LUNCH

12:00 – 1:00

- | | | |
|--|--------------------|---------------------|
| 1. Comments | David Muntz | 12:30 – 1:00 |
| 2. Identifying Priorities (Continued) | Jodi Daniel | 1:00-2:45 |

BREAK

2:45 – 3:00

- | | | |
|--|---------------------|--------------------|
| 3. Identifying Priorities (Continued) | Kate Tipping | 3:00 – 3:30 |
| 4. Summary and Next Steps | Kate Tipping | 3:30 – 4:00 |
- a. Summarize options
 - b. Follow up
 - c. Timeline

THANK YOU!