



The State Designated Entity Health
Information Exchange: Behavioral Health
and Physical Health Care Data Exchange

The Oklahoma Holistic Health Information Project

Final Report
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General Overview of Project and Reason for State Interest/Goals for Participating

The Oklahoma Health Information Exchange Trust (OHIET) is state-beneficiary public trust established by the Oklahoma Legislature to serve as Oklahoma's "Qualified State-Designated Entity" for purposes facilitating and expanding the electronic movement and use of health information among organizations according to nationally recognized standards, and promote, develop, and sustain electronic health information exchanges at the state level. The OHIET implementation plan is based on a "network of networks" model to develop and operate statewide HIE capabilities, accessible to all participating providers. The network of networks will result in an effective statewide HIE for healthcare providers to exchange clinical information through their local HIEs. Quality clinical decision-making will be enhanced by securely and expediently sharing medication histories and laboratory results, electronic prescription history and medical summaries via a continuity of care document (CCD) and other documents at the point-of-care. The Health Information Organizations (HIOs) are the foundation for the statewide network of networks and are committed partners in the Oklahoma Holistic Health Information Project (OHHIP).

While a multi-network infrastructure works well within the political context of the state, it is limiting in that there is no one HIE to modify to meet the requirements of behavioral health consents, particularly that of substance abuse treatment records. The challenge for Oklahoma was to allow behavioral health providers to participate with any HIO, current or future, given the existing level of technology. Another challenge was the wide variation in the use of electronic health records (EHRs), ranging from providers not having any type of an electronic system to providers having an ONC-certified EHR. The OHHIP was designed to meet both the HIOs and providers at their current level of technology. A two-tiered voucher program is being utilized, with priority given to publically funded, not-for-profit, safety net behavioral health providers, who can demonstrate a partnership with another healthcare provider. Behavioral health providers can encourage their partnering providers to join an HIO and take advantage of a similar voucher program now being offered to primary care providers and rural hospitals.

In the voucher program, behavioral health providers work with a certified HIO to connect via a secure, electronic means to communicate, share medical records, perform referrals, obtain lab and pharmacy data electronically, submit reportable data to the Oklahoma State Department of Health (OSDH), and establish interconnectivity to facilitate care coordination. The voucher funding offsets the cost of signing up with a certified HIO to electronically exchange health information. Because of the wide variation in the degree of health information technology and the ability for behavioral health providers to electronically share data, the behavioral health voucher program will be two tiered. The first tier allows the providers to see the HIE data

through a web portal and share information via DIRECT Secure Messaging to other providers using the messaging system. The second tier allows them to share data from their EHR or other systems of records.

The first tier allows providers to send and receive continuity of care documents (CCDs) via DIRECT standard messaging, and query for and view data on individual patients via the web based portal from the chosen HIO. This tier will be important for smaller providers which are unable to afford an EHR at this time and for substance abuse treatment facilities, which fall under 42 CFR Part 2 and cannot comply with the required consent procedures of the law regarding submission of information through an HIE. Voucher value for funding "Tier 1" is \$600 per clinical connections and will be applied towards the cost of contractual agreements made with participant's certified HIO and will include initiation/credentialing fees and subscription service/support. Provider agencies are allowed to choose up to 11 clinical connections. The monthly subscription fee is approximately \$50 per clinical connection so it will be sustainable by providers beyond the time period of the subcontract award.

The second tier permits providers to connect directly with a certified HIO and send structured clinical data using HL-7 protocols for transmission of CCDs. The voucher value for funding "Tier 2" will be \$15,000 for the interface, and will be applied towards the cost of contractual agreements made with a certified HIO and may include interface fees, initiation/credentialing fees, messaging services capable of DIRECT standard messaging or equivalent, and subscription service/support and will be based on the contractual arrangement with participant's certified HIO and their participating behavioral healthcare vendors. In addition, the Tier 2 voucher will support up to 11 clinical connections at \$600 per clinician. This tier will apply to providers who have EHRs in place, regardless of whether or not they have received ONC certification.

Managing the Project to Grant Deliverables/Outcomes

Structured Lab Results Delivery

At the beginning of the project, the extent of structured lab result exchange in Oklahoma was unknown. To determine the level and promote the exchange of lab results, OHIET conducted a comprehensive survey among hospitals and independent laboratories to determine the amount of structured lab results being exchanged, which entities are capable of exchanging lab results, and what the barriers are for those entities that do not have the capacity to send structured lab results.

The survey was administered by the Oklahoma Hospital Association and distributed to independent laboratories and hospitals in September. The following month, responses from 106 hospitals and 19 independent labs were received and compiled. The survey revealed that for hospitals, 62% reported that none of the lab results were sent to an EHR and only 4% were sending lab results in a structured format. Further, 57% reported that they were not using LOINC standards, while 18% did not know and 12% left the question blank. For independent labs, only 34% reported that they were not sending reports to an EHR and 47% reported sending results in a structured format. Over half (53%) of labs were using LOINC standards. To encourage the exchange of structured lab results a voucher program will be issued to foster the exchange of lab results throughout the State.

Because Netsmart is a vendor for several behavioral health providers in Oklahoma, a discussion was held with a Netsmart representative in September to discuss what modules are needed to interface with the lab management systems. Two functionalities are available within the Netsmart EHR depending on whether the lab is internal or external.

Continuity of Care Document Development (CCD)

When the behavioral health workgroup initially met to discuss additional CCD data elements in June, they reviewed the data elements suggested by the HL7 Community-Based Collaborative Care (CBCC) Workgroup. Three major themes emerged. First, some providers already have EHRs that have the capability to send CCDs and they are able to send the needed data through the current structure. They did not want to see the CCD changed because it would cost additional money to have their vendors change the formatting. (The Netsmart vendor mentioned above confirmed that Netsmart products currently are capable of producing a CCD in HL7 format.) Second, they were fearful that physical health clinicians are accustomed to the current CCD and, if it were lengthier, would not take the time to study additional behavioral health data elements. Third, work to include additional behavioral health data elements in a CCD needs to take place at the national level so vendors incorporate the elements into their off-the-shelf products rather than providers having to pay to have them customized.

During the July meeting of the Behavioral Health Workgroup, it was clarified that the CCD structure will not necessarily be modified but that additional codes could be identified for behavioral health issues within the existing fields. This appeased the group's concerns and, after reviewing the Standards & Inoperability (S&I) Clinical Element Data dictionary (CEDD) and the Consolidated CDA Template, the members recommended the following fields be considered for addition to the CCD standards: homicidal and suicidal ideation, living situation, treatment referral, an overall health status, and a level of functioning indicator. The Behavioral Health Workgroup Chair will continue to work with the CBCC through the weekly webinars to ensure standards are set at the national level.

Participation of Core Behavioral Health Team (HIE Coordinator, HIT Coordinator, Medicaid Director, Mental Health Authority Director, Substance Abuse Authority Director) in Ongoing Calls and Activities

Oklahoma had 100% participation of the core team at the kick off meeting, the final learning congress and the majority of the monthly calls. Val Schott is the Executive Director of the OHIET (statewide HIE) and the State HIT Coordinator (40% of the core team), Carrie Slatton Hodges is the Deputy Commissioner for Mental Health and Substance Abuse Services (40% of the core team) and Dr. Garth Splinter is the Medicaid Director (20% of the core team). In July, 2012, the governor transferred the state portion of behavioral health Medicaid funding to the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), which Ms. Hodges oversees.

Behavioral healthcare has been included in the SDE governance structure from the beginning. It was under the leadership of the ODMHSAS Commissioner Terri White, who was the Secretary of Health at the time, that Oklahoma applied for and received the State Health Information Exchange Cooperative Agreement Program (SHIECAP). Legislation appointing the Board of Trustees to act as the governance body for the state HIE also named 17 representatives to serve as an Advisory Board to the Trust, one of which must be a representative from the ODMHSAS and the state Medicaid agency. While the need to include behavioral health was widely recognized by OHIET and the Advisory Board, the SHIECAP funds were earmarked to be used only for providers that qualified for the meaningful use incentive program leaving the majority of behavioral health providers with no means to participate. This subaward was the mechanism needed to financially support the linkages of behavioral health and primary care providers. In addition, funding was used for legal and technical consultants to educate providers about how behavioral health information can be securely shared electronically and to host statewide meetings where information could be easily disseminated.

Statewide Meetings with Providers and/or Consumers

Discussion of Comprehensive Strategic Communications Plan to Educate, Engage and Solicit Feedback from the Behavioral Health Provider Community and its Consumers

The targeted behavioral health providers in Oklahoma are not for profit, safety net providers, who have the least to invest in information technology. This basically results in four groups: the 14 community mental health centers, approximately 80 substance abuse treatment providers, eight therapeutic foster care therapists, and two state-operated psychiatric hospitals, two community-based inpatient units and a community-based crisis center. Each of these facilities

participate in periodic meetings and the Behavioral Health Workgroup Chair attended each group's meeting to educate and engage providers in the project, and received feedback through questions or concerns. The State HIE Coordinator also co-presented at many of the meetings, stressing the need for behavioral health information integration to improve the state's overall health status. Because of the relationship with the Chair, many providers choose to email or call her with questions, not wanting to appear ignorant asking about the process in front of their peers. Other times, the provider would include several of his/her peers on the email thread and a constructive dialogue took place. Below is a list of meeting by date attended by the Behavioral Health Workgroup Chair:

June: The Behavioral Health Workgroup Chair presented at the Substance Abuse Treatment Directors meeting, the Community Mental Health Centers Directors meeting, the Health Home Learning Collaborative, and the Therapeutic Foster Care Association meeting.

July: The Behavioral Health Workgroup Chair attended and answered any questions about the voucher program at the Mental Health Planning and Advisory Council, the Substance Abuse Treatment Directors meeting, the Community Mental Health Centers Directors meeting, and the State-operated Facilities Directors meeting.

August: The Behavioral Health Workgroup Chair attended and answered any questions about the voucher program at the Substance Abuse Treatment Directors meeting and the Community Mental Health Centers Directors Meeting, and the Health Home Learning Collaborative.

September: The Behavioral Health Workgroup Chair attended and answered any questions about the voucher program at the Substance Abuse Treatment Directors meeting and the Community Mental Health Centers Directors meeting.

November: The Behavioral Health Workgroup Chair attended and answered any questions about the voucher program at the Substance Abuse Treatment Directors meeting, the Community Mental Health Centers Directors meeting, the State-operated Facilities Directors meeting and the Health Home Learning Collaborative.

In addition, the ODMHSAS; the Mid-America Addiction Technology Transfer Center; and the Oklahoma Substance Abuse Services Alliance, a provider organization, collaborated to host the Oklahoma Healthcare Changing Landscape training, which has evolved into learning collaborative. Before the training, providers were asked to complete a web-based readiness survey, "Behavioral Health Providers in the Era of Healthcare Reform." Leaders in healthcare reform were brought in for an all-day meeting with providers. The survey results of Oklahoma's providers were compared to nationwide data to determine areas of strengths and weaknesses. The consultants worked with substance abuse treatment providers to develop strategies to respond proactively to the range of regulatory, policy, funding, business and clinical challenges,

including information technology and data management. Due to the positive feedback from the providers, the project is now being extended to focus on the three top priorities, one of which is health information technology. Providers will apply to participate in the learning collaborative and will report progress during bi-monthly coaching calls.

The ODMHSAS and the state Medicaid agency is submitting a state plan amendment to the Center for Medicare and Medicaid Services to implement a patient-centered health home to be housed at each of the 14 community mental health centers. Requirements include the health home provider have structured, interoperable health information technology systems, and procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every member within 18 months of initiation. The plan requires that the health homes make use of available HIT and accesses data through the HIO or DIRECT messaging to conduct these processes. Funding from this sub-award has greatly supplemented the providers' efforts to obtain the needed technology to meet these requirements. An ongoing learning collaborative began in January, 2012 and will focus on the "clinical buy-in" of HIE in the February, 2013 meeting.

Provider Engagement in Shaping the Legal and Operational Framework for Data Exchange

Provider input in shaping the legal and operational framework has come from the monthly meetings mentioned above, the two statewide meetings and numerous phone calls and email communications. The biggest issue identified was that behavioral health should be an opt-in model, contrary to the opt-out model used for physical health in the State. Even for mental health records, which do not require consent to release information, providers insisted that consent should be required to ensure the trust that is necessary for the therapeutic relationship remains intact. During the summer, the group developed policy and procedures instructing behavioral health providers to use an opt-in method and the requirements for doing so. Specifically, the responsibility for keeping certain data out of the HIE rested with the behavioral health provider, not the HIE.

In September, the Behavioral Healthcare Workgroup reviewed the draft policies for the sharing of behavioral health information through HIEs and amended them to be "guidelines," and left the decision of whether to use an opt-in or opt-out mechanism to the individual provider. All of the providers in the workgroup stated that they will utilize an opt-in method at their individual agencies but felt the group should not make that decision for provider agencies that were not publicly funded.

In October, the behavioral health guidelines were presented to the Oklahoma Health Information Exchange Trust and were approved pending recommended changes. Some trustees felt that there should be stronger language in the guidelines emphasizing that if the behavioral health provider chooses the opt-in mechanism, any divergence from the policies of the selected HIO to make consent more stringent is the sole responsibility of the behavioral health provider. The following month the amended behavioral health guidelines were presented to the Oklahoma Health Information Exchange Trust and approved. The guidelines have been posted on the OHIET website.

Consumer Engagement in Shaping the Legal and Operational Framework for Data Exchange

Due to the technical nature of the project, consumer engagement was difficult to achieve and has been limited to consumer participation on the Behavioral Health Workgroup.

In July, the workgroup chair presented at the Mental Health Planning and Advisory Council, which includes both mental health and substance abuse consumers, to educate them about the project and invite them to participate on the workgroup. The Planning Council was very interested in the project and asked the Behavioral Health Workgroup Chair to keep them informed of the progress but at this time, involvement with the Behavioral Health Workgroup has been very limited. The Chair continues to attend the Planning Council meetings and keep the members informed of the project. However, one member of the Behavioral Health Workgroup does have lived experience, along with a public informatics certificate from Johns Hopkins School of Public Health, and contributed greatly to policy development.

Initial and Ongoing Statewide Meetings Held

The first statewide provider meeting on behavioral health information exchange was held on May 23. Over 50 providers participated and 100% rated the meeting as good or excellent (55%, 45%, respectively). Presentations included: an overview of the Oklahoma Health Information Exchange Trust by the State HIE Coordinator, the connection between the mind and body in overall health by the ODMHSAS Commissioner, the legal aspects of sharing behavioral health data by the legal consultant, the technical aspects of sharing behavioral health data by Mike Lardiere of the National Council for Community Behavioral Health, things to consider when purchasing an EHR by the Director of the Regional Extension Center, and a brief panel discussion from the three certified HIOs. Through the monthly meetings attended by the

Behavioral Health Workgroup Chair and email, feedback from providers was obtained. This feedback was incorporated into the agenda for the second statewide provider meeting.

The second statewide provider meeting was held on July 12. As requested, the legal consultant again presented on the legal aspects regarding sharing of behavioral health information. The Chair of the OHIET presented on the basics of an HIE and considerations when choosing an HIE. Each of the three certified HIOs presented on the benefits of their respective HIEs and had vendor booths so providers could have one-on-one discussions with representatives from each of the HIOs.

Progress towards Behavioral Health Provider Exchange in the HIE

Barriers Encountered

Barriers encountered thus far have been a lack of understanding on the providers' part. Many are intimidated by technology or by the idea of partnering with primary care providers, which tend to operate differently. However, the biggest barrier encountered is the longstanding belief that the confidentiality of behavioral health information is an essential element in delivering services and sharing this type of information is contrary to best practice. The statewide meetings have been used to educate providers on the need for integration and the security of the technology involved. The need for information sharing in order to provide holistic care has been stressed in several meetings. The ODMHSAS Commissioner continues to stress at every speaking engagement with providers that, "Behavioral health is essential to overall health and overall health is essential to behavioral health."

Activities

In early summer, the Behavioral Healthcare Workgroup developed language for the behavioral health voucher announcement. The voucher program was set up much like that of the vouchers for "eligible providers and hospitals" but did not require the recipient to have an ONC-certified EHR or be in the process of applying for the meaningful use incentive payments. To ensure consistency among the voucher processes, funds were subcontracted with the OHIET to administer the voucher funding to behavioral health providers. In August, the OHIET approved the behavioral health voucher announcement and the proposed subcontract budget, and in September the subcontract with the OHIET was executed. On October 1, the behavioral health HIE voucher application was released.

Early in the process, the Behavioral Health Workgroup Chair had discussions with two vendors, Netsmart and OrionNet Systems, who have contracts with the majority of behavioral health providers to discuss group rates for an interface for their customers. The two vendors have worked with the selected HIO to ensure cost efficiency of voucher funds.

Number of Providers Signed Up

Prior to the subaward there were 21 behavioral health providers linked to an HIE in the State. These providers were associated with primary care hospitals or large health centers. There were no safety net behavioral health providers who serve individuals with no resources to pay for treatment. Through this project, funding was made available to 27 behavioral health agencies for 365 clinical connections with HIEs. Tier 1 vouchers were used to connect 23 individual clinicians to an HIE through DIRECT and a web portal at seven agencies, and Tier 2 vouchers provided full interfaces to 20 agencies, with 342 individuals clinicians having connections. All of the providers participating in the voucher program serve individuals through Medicaid, state or federal block grant funding.

Progress towards Behavioral Health Provider Exchange Using NwHIN DIRECT

The NwHIN DIRECT is being offered through both Tier 1 and Tier 2 levels of the voucher. The substance abuse treatment programs are being encouraged to use this as a mechanism for sharing treatment data until technology can exchange data at the granular level required by 42 CFR or modification of the law. A consultant on the project is investigating a front-end mechanism that would allow for the secure exchange of substance abuse treatment data through an HIE; however, that solution is still in the testing phase and will not be implemented in the near future. Many of the Tier 2 agencies have internal substance abuse treatment programs and are utilizing DIRECT for clients treated in these programs. Through the voucher project 152 DIRECT connections have been funded for a 12-month period.

Policy and Regulatory Issues

Legal and Regulatory Barriers

The major policy and regulatory issue that has arisen with linking behavioral health records is the stringent requirements of 42 CFR Part 2. There are several limiting factors due to this. Currently, all three HIOs utilize an all-or-nothing approach. That is, all parts of the individual's treatment record are shared or none of it is disclosed. None of the HIOs currently have a consent registry so it is not possible to determine to whom individuals has consented to share their treatment information, for what purpose, and a consent end date or event. One suggestion has been to have the individual consent to any active provider participating in the

HIO at the time of the consent. However, the HIOs are not able to determine who was a participant at the time of the consent.

Policy Development

Given these HIE technological limitations, a draft policy was developed that required substance abuse records only be shared through DIRECT messaging until the restrictions are reduced or until a technology practice is identified that can comply with 42 CFR Part 2. This policy has been amended to be a guideline because OHIET does not have any authority to restrict the sharing of data, particularly concerning providers that are not Part 2 programs. Because Oklahoma is an opt-out, all-or-nothing state, providers that want to require consent before sharing mental health records, must be able to filter the data through their EHRs. If their EHRs are not capable of filtering substance abuse and unconsented mental health records, they must use DIRECT messaging. This guideline impacts the behavioral health EHRs in that additional filters will need to be built before exchanging data through the HIE. It is important to note that one of the three HIOs is exploring a method that may allow substance abuse treatment records to be shared through an HIE. More research is needed to determine the feasibility and timeframe of such technology in Oklahoma.

Audit Mechanisms

All HIOs have written policies limiting the access and use of data. The HIOs log all user activity including: user login/logoff date and time, device address, actions taken by user, type of data being accessed/activity being performed, user's justification, and date/time of each event. All logged activity is retained online and is available to the HIO administrative users. The logs are used by the HIOs to support the appropriate use of data, ensure patient confidentiality, maintain secure operations, support investigations of breaches and respond to requests about access to PHI through the HIOs.

The HIOs enables administrators or "trusted sources" to perform regular audits, looking at all records accessed by the provider, all provider requests for a specific patient and weekly account levels. The HIOs utilize community-level audits as well. Each network has and is continuing to develop more proactive methods for monitoring inappropriate access, some of which include: proactive monitoring of VIP records, scrutiny when an organization's users access records on patients without supplying data for those patients as well, and reports for excessive number of provider lookups. In addition, every user must attest that they have a treatment relationship before looking up any record, unless accessing the HIO's record directly via their EHR, in which case the patient identity supplied by the EHR is sufficient to assume a treatment relationship. One HIO is working with the University of Tulsa's Institute for Information Security (iSEC), a leader in the field of information security assurance, to assess, monitor and enhance their security controls. All three HIOs stress that this is an ongoing process and are continually adding mechanisms as new practices are identified by the field.

The Behavioral Health Workgroup chair spoke with the President of OrionNet Systems, a local EHR vendor, and representatives from Netsmart, the two largest vendors, to ensure fields could be added to filter out behavioral health records if the fields did not already exist. Both companies stated that this could be done in a timely manner.

Legislative Changes Required to Implement Exchange

There are no anticipated legislative changes. Oklahoma amended its state mental health law in 2005 to parallel HIPAA regarding the release of records.

Infrastructure Development Required by HIE

In order to include substance abuse treatment records that fall under 42 CFR Part 2, much infrastructure work would need to be done on the HIEs. This work would also be required of any new HIEs that come aboard in the future. At this time, the HIEs have an “all or nothing” approach to sharing data. Data cannot be filtered to specific providers or for specific purposes. Further, none of the HIEs currently have a consent registry. When asked about building this technology, all three of the HIOs were concerned about sustainability. They felt at this stage in their development it was more beneficial to target the larger pool of providers who did not have these constraints than to invest a large amount of resources in retooling the HIE for a few providers. In order to provide access to physical health data to substance abuse agencies and allow them to share substance abuse records securely, DIRECT messaging and web portals will be utilized. Development will be done on the EHR side to filter out records that are not to be submitted to an HIE.

Pilot Site Selection

The project has been implemented statewide. Targeted providers were not for profit, safety net behavioral health providers. This group of providers was selected because they have the least amount of resources to invest in health information technology. Prior to this project, all of the behavioral health providers involved with an HIE were either connected to a primary care hospital or larger medical complex.

Coordination with National and State Partners

In October, the Chair of the Behavioral Health Workgroup had a phone conversation with Matt Monroe, Altarum, working with the Michigan Health Information Network (MHIN) to discuss

how Oklahoma was including behavioral health providers in its HIE efforts. Due to the many similarities among the two states' processes, a larger call with representative from both state HIE organization was planned for November. Four representatives from the MHIN and four representatives from the OHIET had a webex. The Oklahoma behavioral health voucher program was discussed and the application was shared. Other resources were discussed and future webexes are being planned to continue the collaboration.

In January, the HIT Coordinator provided information to officials with the eHealthConnecticut HIE who were also interested in including behavioral health information. A similar call is planned with Nebraska.

Barriers/Obstacles to Behavioral Health Provider and Physical Health Provider Data Sharing in the HIE

At this point, the restrictiveness of 42 CFR is seen as the biggest hurdle for exchanging substance abuse records through an HIE. Until such time as the requirements are eased or technology is capable of tagging individual data elements, substance abuse records will not flow into the HIE but will be sent through DIRECT. However, substance abuse providers will still be capable of viewing physical health records of their clients through the HIE web portals.

Operational Issues for the HIEs

On the physical health side, similar voucher programs were developed to encourage physical health providers to participate in HIEs. There is a concern that until a critical mass of providers contributing data to an HIE is reached, clinicians will not think it is worth the time to query for patients through an HIE. Unfortunately, due to the delay in the transfer of the State Designated Entity designation, the release of the vouchers for rural hospitals and the eligible professional voucher was delayed until fall of 2012. This also means that behavioral health providers are competing with primary care providers and hospitals HIE staff resources to develop an interface with the three HIOs, causing a slight delay in deployment. However, the HIOs' training staff have been very responsive to questions raised by behavioral health providers and are using the time to educate and engage clinicians in the process.

Operational Issues for the Providers

For behavioral health providers, agreement among the HIEs on what types of data and how the data could be shared has taken some time to obtain. The current guideline *recommends* that behavioral health data be treated as an opt-in process, as opposed to the opt-out method used on the physical health side. If the provider chooses the opt-in method, rather than retool the

HIEs, the provider's EHR must have the ability to filter the records. In addition to the technical requirements, provider facilities must thoroughly think through their workflow, how their programs are set up and coded within the EHR and what safeguards will be in place to ensure the filtering fields are working correctly.

Cost Constraints

Initially, it was thought that a provider agency could have a DIRECT connection that would serve the entire agency; however, current requirements demand that the connection be tied to a specific clinician to ensure controlled access. DIRECT connections were not originally funded for facilities applying for the full interface. The budget had to be reworked to ensure facilities were properly funded to take full advantage of the HIEs services while discouraging the use of vouchers to over exceed what the facilities could sustain once the voucher period has ended. Since many of the mental health providers use the same vendor, discussions are underway to determine "group" procurement costs, further stretching the purchasing power of the project.

HIE Tool Kit/ Education Package Development for Providers Identified

In May, a white paper was developed by the legal subcontractor title, "Inclusion of Behavioral Health Information in Exchanges: Can it be done?". This document is written in lay person's terms to clearly identify the applicable laws and their impact on the inclusion of behavioral health information in HIEs. In addition to the relevant state and federal laws, the paper also discusses trade groups representing psychiatrists, psychologists and other behavioral health practitioners, which remain concerned about protecting patient confidentiality and the electronic exchange of behavioral health information. Some of these groups have promulgated codes of ethics and other directives that impact and may limit the electronic exchange of such behavioral health information without patient consent. The white paper was presented at the first statewide providers' meeting and also provided in electronic format.

In September, draft guidelines were reviewed by the Behavioral Health Workgroup. Because the guidelines were originally drafted as policy and procedures, a "provider friendly" version was developed for providers, using layman's terms and examples.

The behavioral health guidelines were presented to the Oklahoma Health Information Exchange Trust and were approved pending recommended changes in October. The following month, the amended behavioral health guidelines were presented to the Oklahoma Health Information Exchange Trust and approved. The guidelines have been submitted for posting on the OHIET website.

Lesson Learned/“Recommended Practices”

Consent Process

Oklahoma has developed a standardized Authorization for Release of Information, which was codified by the Oklahoma State Legislature and adopted by the Oklahoma Board of Health in 2009. Providers are not required to use the Authorization for Release of Information but they are required to accept it. The legal subcontractor has determined that no changes are needed to the authorization for use with HIEs. The providers' Notice of Privacy should reflect that, with consent, data will be shared through an HIE. This recommendation is reflected in the Behavioral Health Guidelines. However, many providers use their own specific consent forms and may modify them per their own legal counsel. Oklahoma will continue to participate in the discussion among awardees for a 42 CFR compliant consent form for future use for substance abuse record exchange.

In Oklahoma, an all-or-nothing approach is used, meaning that all information exchanged can be viewed by other providers involved in the care of the client. Further, the purpose of the use of the data is not identified, that is, all information may be used for treatment, payment or operations. With physical healthcare records, opting out of the exchange means that none of the client's data can be included. However, the exclusion is provider specific. If a client chooses not to share their behavioral health records, they can still participate in an exchange for their physical health records and vice versa.

Because the filtering of records falls on the provider organization, the ability to track an event, which ends the consent, will be left up to each provider facility. The ability to track an event rather than a date that can be programmed to expire automatically will be a much bigger burden for the provider staff. There is concern that such events may occur without the consent being withdrawn.

Provider Agreements

Each HIO uses standard agreements with each of its provider organizations. The HIOs will determine whether these agreements need to be modified due to the opt-in process for behavioral health and the responsibility for filtering records on the provider side.

Final Statewide Meeting Held

The second statewide provider meeting was held on July 12, 2012. Val Schott, Executive Director of the OHIET and the State HIE Coordinator, welcomed attendees and stressed the importance of sharing health records electronically and in a standard format. As requested, Cori

Loomis again presented on the legal aspects regarding sharing of behavioral health information. The Chair of the OHIET, Dr. Roswell, presented on the basics of an HIE and considerations when choosing an HIE. Each of the three certified HIOs presented on the benefits of choosing their respective HIEs and had vendor booths so providers could have one-on-one discussions with each of the HIOs. Forty-one individuals attended the meeting and represented behavioral health providers, EHR vendors, and HIOs.

Next Steps and Future Direction for Behavioral Health Integration in the State

As stated above, the targeted providers were safety net providers. While they may serve other populations, the definition of a “safety net” provider required that they must serve Medicaid or state-funded individuals with no other pay source. The ODMHSAS is the Single State Authority for Substance Abuse, the State Mental Health Authority and oversees the state share of the Medicaid behavioral health funds. Therefore, all of the voucher applicants have a relationship with the ODMHSAS and engage in many training opportunities provided through the ODMHSAS. As training needs are identified, trainings will be developed and made available to the provider community.

All of the voucher applications were due December 29, 2012. The month of January was spent notifying providers of their acceptance in the program and notifying HIOs of respective applicants and contact information. On February 6th, 2012, a kick off meeting is being held in which each HIO will meet with its providers and hold a clinician orientation to HIE.

The State HIT Coordinator writes monthly columns in state medical associations' journals and is publishing articles about the behavioral health voucher program to educate primary care providers on the need to partner with behavioral health providers and the ability to do so through electronic interchange.

Dissemination Activities/Plans/Accomplishments

Interstate

As mentioned earlier, Oklahoma has held discussion with the Michigan Health Information Network and eHealth Connecticut HIE about the voucher project and related products. A future call is being planned with Nebraska.

Intrastate

Project dissemination has been through list serves, through the statewide provider meetings and presentation at various meetings and associations' new letters. As mentioned above the Behavioral Health Workgroup Chair attended 19 monthly meetings of various groups to inform potential applicants of the benefits of participation and the process for applying. This same forum will be used to disseminate progress and accomplishment.

National Meetings

The Oklahoma Holistic Health Information Exchange Project will co-present with the other four states at the National Council for Behavioral Health's Annual Conference.

Infrastructure Development, Prevention and Mental Health Promotion (IPP) Measures

The number of organizations making changes to accountability mechanisms in order to improve mental health-related practices/ activities that are consistent with the goals of the grant

Twenty seven publically funded, safety net behavioral healthcare providers are participating in the voucher program. This includes the state psychiatric hospital, the state forensic hospital, 14 community mental health centers, 9 substance abuse treatment agencies, a stand-alone inpatient facility and a community-based crisis center. Through these facilities, a total of 365 clinical connections have been established.

The number of communities that established management information/information technology system links across multiple agencies in order to share service population and service delivery data as a result of the grant

The 27 agencies and affiliated satellites participating in the behavioral health voucher program cover all 77 counties in the State. In State Fiscal Year 2012, the unduplicated count of persons served across the 27 agencies was 68,826.

Policy Development

As stated earlier, the Behavioral Health Workgroup initially developed policies and procedures for exchanging behavioral health records through an HIO in Oklahoma. This document was later changed to guidelines since OHIET not does have any regulatory authority, particularly with

non-publically funded providers and out-of-state providers. The guidelines address the use of an opt-in policy for behavioral health if providers choose this consent model, the requirements for their EHR to be able to filter out records without consents and the liability of mis-sharing information resting on the provider, not the HIO. The guidelines are broken out by mental health, substance abuse and co-occurring treatment records. A provider friendly version of the guidelines was developed using layman's terms and examples. The guidelines will be included in the OHIET Privacy and Security Framework and are being disseminated through the OHIET website.

Organizational Change

Change at the organization level, both state and provider agency level, began prior to the sub award due to the requirements of the American Recovery and Reinvestment Act and other federal initiatives. The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS); the Mid-America Addiction Technology Transfer Center; and the Oklahoma Substance Abuse Services Alliance, a provider organization, collaborated to host the Oklahoma Healthcare Changing Landscape training. National leaders in healthcare reforms were brought in for an all-day meeting and worked with substance abuse treatment providers to develop strategies to respond proactively to the range of regulatory, policy, funding, business and clinical challenges. The provider association has now taken on the project, with support from the ODMHSAS, to continue the work that was started.

The ODMHSAS has also started a Learning Collaborative for mental health providers to become patient-centered health homes. Two large topics deal with workforce training and the need for electronic data interchange with all treating providers. All participating providers must be linked to an HIO and be able to exchange treatment data electronically within 12 months of becoming a health home.

Workforce Development

As mentioned in the previous section, workforce development has been done at a high level through provider meetings and through two learning collaboratives. More specific training will be provided by the HIOs at the time of implementation. A kick-off meeting for clinical staff is scheduled for February 6th, in which the HIOs will meet individually clinical, administrative and privacy staff from their respective agencies.

Financing

The majority of the sub award, \$519,000, was used for vouchers to behavioral health providers to redeem with one of the three certified HIOs. The vouchers provide two tiers of connectivity to meet providers at all level of technology.

Tier 1 utilizes DIRECT secure messaging, to send and receive secure email with the option to attach documents that may include protected health information (PHI), as well as the ability to query for and view PHI from other health care providers on individual patients with a treatment relationship via the web based portal from the chosen HIO. Providers subject to 42 CFR Part 2 (substance abuse treatment programs) can benefit by utilizing DIRECT messaging to share a consenting patient's PHI securely with another provider. Voucher value for funding "Tier 1" is applied toward the cost of contractual agreements made with participant's Certified HIO. This could include Tier 1-specific fees including initiation/credentialing fees and subscription service/support. Tier 1 funding is on an individual clinician basis. Provider agencies must specify how many individual clinicians they are applying to fund for HIE with DIRECT services. Funding is intended to cover approximately a one-year period.

Tier 2 vouchers allow the creation an electronic connection between the provider organization's electronic health record and a chosen certified HIO to send structured clinical data for transmission of continuity of care documents (CCDs) as well as any other structured clinical data and unstructured data such as reports or other documents which the chosen HIO is capable of receiving/rendering for viewing. Voucher value for funding "Tier 2" is applied toward the cost of contractual agreements made among voucher recipients, their EHR vendor and chosen HIO. This could include Tier 2-specific fees, including Interface fees, initiation fees, and subscription service/support fees and is based on the contractual arrangement with participants' certified HIO. In addition to the interface funds, provider agencies may request funding for up to 11 clinicians for DIRECT secure messaging, with all the functionality of Tier 1 Interoperability.

Partnerships/Collaboration

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Behavioral healthcare has been included in the SDE governance structure from the beginning. It was under the leadership of the ODMHSAS Commissioner Terri White, who was the Secretary of Health at the time, that Oklahoma applied for and received the State Health Information Exchange Cooperative Agreement Program. Legislation appointing the Board of Trustees to act as the governance body for the state HIE also named 17 representatives to serve as an Advisory Board to the Trust, one of which must be a representative from the ODMHSAS and the state Medicaid agency. However, a lack of resources and education on the provider side prevented true participation in health information exchange. The sub award has not only allowed for the voucher program but also provided funding for legal and technical consultants to educate

providers about how behavioral health information can be shared electronically and to host statewide meetings where information could easily be disseminated.

Through the sub award project, many individuals and groups have worked to ensure its success. These include the OHIET, the three HIOs, the OHIET Advisory Board, the Behavioral Health Workgroup, the Regional Extension Center and, of course, behavioral health providers. Members from all of these groups gave of their time over the holidays to ensure a successful application, have been involved in many discussions to develop the best procedures for inclusion of behavioral health, developed guidelines for behavioral providers, presented at statewide and organizational meetings, set up vendor booths, and personally worked with providers in determining what arrangement best met their business needs. The OHIET Chief Executive Officer begins nearly every presentation with the statement, *"Primary health includes physical health, behavioral health and oral health. If you short change one component, we will not have the outcomes we desire or need."*

Targets of Practice

The targets of practice are not for profit, safety-net, behavioral health providers. Safety net providers are defined as providers who serve individuals that have no personal funding for treatment and must rely on public funding such as Medicaid or state funding. This group was targeted because these providers generally have the least resources and serve individuals with little resources.

Accountability

To ensure accountability, milestones were built into each tier and must be completed before the voucher is redeemed. For Tier 1 the following milestones must be completed:

- Provider has been credentialed and has an Active Account with Certified HIO
- Provider has looked up a patient record in the HIE
- Provider has sent and received a secure message via the Certified HIO's secure messaging system

For Tier 2 the following milestones must be completed:

- Provider has a live data feed established and in use with a Certified HIO
- Provider's EHR is passing structured clinical data to the HIE in standardized form (CCD's, Labs, Medications, Vital signs, etc.)
- Live data feed has sent structured clinical data of CCDs or other structured clinical data compliant with ONC accepted interoperability standards.

Oklahoma Appendix

[Behavioral Health Guidelines Friendly](#)

[Behavioral Health Guidelines](#)

[Behavioral Health Voucher Announcement](#)

[Healthcare Workshop Agenda](#)

[Legal Aspects of Sharing Behavioral Health Data](#)