Behavioral Health Integration and Data Exchange:

Privacy and Exchange Considerations for Community Health Centers

September 2016

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ACKNOWLEDGEMENT

The National Association of Community Health Centers (NACHC) promotes the provision of high quality, comprehensive health care that is accessible, coordinated, culturally and linguistically competent, and community-directed for all underserved populations

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DISCLAIMER

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant U30CS16089, "Technical Assistance to Community and Migrant Health Centers and Homeless." (Total grant award is $6,375,000.00. Zero percent of this project was financed with non-governmental resources.) This information or content and conclusions are those of the author(s) and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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1.0 Executive Summary

Health care in the United States is moving from a sole focus on physical health, to incorporating an individual's mental health as well— a whole-person health focus. Community Health Centers (CHCs) are ideal locations from which to deliver behavioral health services[1]. Health centers are organizations that receive grants under the Health Center Program as authorized under section 330 of the Public Health Service Act, as amended.

In 1943, President Harry Truman signed the national Mental Health Act which led to the creation of the National Institutes of Mental Health and the beginning of community behavioral health services. It soon became clear that institutions were not the best place to treat mental illness. Nonetheless, community behavioral health was notoriously underfunded until the early 2000's, when George W. Bush began increasing funding requests after years of declining federal dollars.

Practically speaking, CHCs are health care organizations that focus on all the determinants of health-physical, mental and social. Not only have CHCs long held a focus on patient wellness, they are trusted health partners within the communities they serve. It makes sense, therefore, that as more is learned about the large numbers of people whose mental health and other behavioral issues go untreated[2], CHCs will want to integrate those services within their core offerings to serve this unmet need.

Integration with behavioral health services can take many forms, from primary care practitioners (PCPs) reaching out to psychiatrists to learn more about a patient's medications, to CHCs partnering with behavioral health providers to offer co-located services within their clinics, to CHCs actually hiring behavioral health staff and providing behavioral health screenings and brief interventions alongside, or integrated into, other assessments and treatments already provided. Although the methods for delivering integrated care vary, the evidence shows that the integration of behavioral and physical health care improves health care outcomes, thereby increasing patient engagement and satisfaction.[3]

However, because behavioral health services deal with sensitive issues of a personal and sometimes compromising nature, they must be delivered – and health information kept and shared – with increased planning and protection. On the federal level, there are regulations that guide providers in how to secure and safely share protected health information for the patients they serve. These regulations, called the Health Insurance Portability and Accountability Act (HIPAA), were enacted in 1996 and updated in 2013 to provide health care coverage continuity, ensure greater accountability, and simplify administrative functions within the health care industry.

There is also a similar, but more restrictive, federal regulation that governs the confidentiality of drug and alcohol abuse treatment and prevention records. These regulations, whose enforcement is overseen by the Substance Abuse and Mental Health Services Administration (SAMHSA), were first enacted in 1972 and updated in 1987.

1 Throughout this paper, we use Behavioral Health to refer to mental health and substance abuse treatment services.

2 National Alliance on Mental Illness Fact Sheet; **http://www2.nami.org/factsheets/mentalillness_factsheet.pdf**

3 Butler, Mary, Robert l. Kane, Donna McAlpine, Roger G. Kathol, Steven S. Fu, Hildi Hagedorn, and Timothy J. Wilt, Integration of Mental Health/Substance Abuse and Primary Care, Evidence Report/Technology Assessment Number 173, U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2008.

These regulations are often referred to as "42 C.F.R. Part 2" because of their location in the code of federal regulations.[4] These regulations, in general, require that covered providers obtain explicit patient consent before sharing any details regarding the treatment of patients receiving substance abuse services.

Most states also have their own statutes and regulations that further govern how physical health, mental health and substance abuse treatment information must be protected, and what requirements must be followed in order for that information to be shared. Since storage and exchange of information is a cornerstone functionality of any integration effort, this issue brief strives to illuminate the ways that a CHC can successfully navigate the requirements to both protect the privacy rights of patients, but also provide care in a way that positions treatment providers to gain insight into the patient's current health concerns and recommend the best treatment possible.

4 Health Information and the Law; **http://www.healthinfolaw.org/federal-law/42-cfr-part-2**

2.0 Drivers for Integrated Care at Community Health Centers

Integrating behavioral health services into a CHCs core offerings has moved from a question of "if" to a matter of "when" and "how." A myriad of statistics have been gathered about the benefits of providing behavioral health services within the locations where people seek physical health care.[5] In addition, many CHCs are finding that offering integrated behavioral and physical health is an effective way of achieving the "Triple Aim"[6] of health care:[7]

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the health of populations; and
3. Reducing the per capita cost of health care.

One of the strongest ways for a practice to achieve the Triple Aim is for that organization to take ownership of the full set of services, expenditures, and patient experience, whether the patient receives services at that organization or in coordination with other providers. To further the goals of the Triple Aim, many practices are turning to a model commonly known as integrated care. Integrated care forms the basis for a patient-centered approach by putting the patient's symptoms, needs, and health at the center of treatment decisions and services.

In addition to recognizing the value of patient-centered care, another driver pushing integrated care as a key strategy is the move from transaction to value-based payments that reward quality over quantity of services. In other words, providers are increasingly being paid based on the overall health of the patients they serve rather than the actual services provided. Whether through implementation of patient-centered medical homes or private payers enacting incentives for health improvements, the data is clear that patients' with co-occurring behavioral and physical health symptoms do better and cost less when treated in integrated settings.[8,9]

Finally, simply informing a patient of the adverse effects of their lifestyle on their health often has little effect on behavior change. For instance, informing a patient that the extra weight they carry increases their risk of heart disease, or informing an avid smoker that their life expectancy is significantly curtailed as a result of that habit, does not typically result in change. However, embedding individuals whose training and orientation is to support behavioral change can dramatically improve health by providing patients with concrete tools that support taking new action, on their own behalf, to improve their health.

5 American Hospital Association, *Trendwatch* (January 2012). Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes

6 Institute for Healthcare Improvement, 2016; **http://www.ihi.org/engage/initiatives/tripleaim/pages/default.aspx**

7 Institute for Healthcare Improvement,2016; **http://www.ihi.org/Topics/BehavioralHealth/Pages/default.aspx**

8 A 2001 study of veterans attending an integrated primary care - mental health clinic found that the mean cost per consumer in the integrated mental health clinic was $1,533 **less** than in the general VA medical clinic. (Providence, RI VA Medical Center; 2012)

9 GAO.gov, Medicaid: A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures, U.S. Government Accountability Office, http://www.gao.gov/assets/680/670112.pdf

3.0 Levels of Integrated Care

Definitions of integrated care range from very broad—where only a partnership among providers is required— to narrow where a fully shared treatment plan is required. The common denominator to all definitions is the requirement that some communication or coordination between providers exist to meet both the mental and general health needs of patients. One definition that captures all varieties of integration is:

> "… integrated mental and physical health care occurs when mental health specialty and general medical care providers work together to address both the physical and mental health needs of their patients. Integration can work in two directions: either (1) specialty mental health care introduced into primary care settings, or (2) primary health care introduced into specialty mental health settings."[10]

As the above definition states, integration can include bringing behavioral health services into a general medical facility as well as bringing general medical expertise and services into a specialty behavioral health clinic. However, there is much evidence for the former (integration into CHCs) having broader health implications for a number of reasons, including: [10]

1. Persons with mental health problems often do not receive treatment. According to a study by the National Alliance on Mental Illness (NAMI), approximately one in four adults in the United States suffers from a mental illness in any given year, and many do not seek treatment, or when they do, they receive inadequate care.[11]

2. Persons with mental health problems are as likely to be seen in the general medical care sector (23 percent) as in the specialty mental health care sector (22 percent).[12]

3. Patients are much more likely to see a primary care physician (PCP) than a mental health specialist annually; therefore, PCPs may be in the best position to identify and treat common mental health issues. [10]

4. Many people with mental health problems also have significant physical health problems such as cardiovascular disease, pulmonary disease or diabetes. Mental health issues tend to exacerbate the symptoms of physical disorders. Therefore, offering strategies and support for lowering mental health symptoms can provide the needed supports for a patient to better manage their physical health care.[10]

10 Butler, Mary, Robert l. Kane, Donna McAlpine, Roger G. Kathol, Steven S. Fu, Hildi Hagedorn, and Timothy J. Wilt, Integration of Mental Health/Substance Abuse and Primary Care, Evidence Report/Technology Assessment Number 173, U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2008.

11 National Alliance on Mental Illness Fact Sheet; **http://www2.nami.org/factsheets/mentalillness_factsheet.pdf**

12 Wang PS, Lane M, Olfson M, et al. Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. [See comment]. Archives of General Psychiatry 2005 Jun; 62(6):629-40

5. Finally, there is strong evidence that care for common mental health problems (e.g. depression and anxiety) can effectively be delivered in the primary care setting, although in usual practice the care often falls below quality standards.[13]

One helpful model for determining where a CHC is in terms of the transformation to providing fully integrated care was developed by The Center for Integrated Health Solutions (CIHS). CIHS is a collaborative funded jointly by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), and run by the National Council for Behavioral Health. This model provides an integration continuum from collaboration at a distance (Coordinated) to full integration (Integrated).[14]

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

In this model, the level of communication, technology and clinical integration increases as one moves from left to right along the continuum. Here a few characteristics to help you determine where your practice may be:

1. **Coordinated Care:** (Levels 1 and 2): In these levels of integration, providers and staff at the CHC may be aware that their patients are receiving mental health or even substance use treatment services elsewhere. In some cases, providers may confer with the psychiatrist at the behavioral health practice regarding medications and diagnosis. Some CHCs provide depression, anxiety or substance use screening services and then refer patients elsewhere for additional behavioral health support. Electronic documentation of patient

13 Stein MB, Sherbourne CD, Craske MG, et al. Quality of care for primary care patients with anxiety disorders. American Journal of Psychiatry 2004 Dec; 161(12):2230-7.

14 Heath B, Wise Romero P, and Reynolds K. **A Review and Proposed Standard Framework for Levels of Integrated Healthcare**. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

records is shared between the facilities on a limited basis. Typically, there is simply an increased awareness that certain patients may need – or may be getting – additional support for their mental health or substance use issues, but clinical practice is not substantially altered.

2. **Co-Located Care:** (Levels 3 and 4): In this case, the CHC has made the commitment to bring some type of behavioral health services onsite. These onsite behavioral health staff are available for consults with providers to lend additional support for clients in need; in some cases providers even see these clients for short term therapy at the CHC. If patients require longer term treatment, they are referred externally for those services. Charting and billing typically occurs through the electronic health record at the CHC.

3. **Full Integration:** (Levels 5 and 6): The commitment at these levels is to move to a more team-oriented care delivery model where a key member of the treatment team is skilled at behavioral health treatment and support. One of the characteristics of a CHC operating at this level of integration is that treatment is no longer offered in a siloed way. For instance, if the patient is battling getting their diabetes under control, the treatment options offered would include a blended physical health / behavioral health approach in such a way that the patient would not discern that they are receiving separate treatment. One characteristic of this operationally is that the treatment team's care plan is blended with all members equally, making them all responsible for the outcomes.

In many states, CHCs and Community Mental Health Centers alike are beginning to assess their practices along these six levels of integration as way to benchmark their current capabilities and create a plan for improved methods of integration over time.

In Colorado, the Colorado Behavioral Healthcare Council, a statewide membership organization for Colorado's network of community behavioral health providers, hosts a map for its members that allows them to indicate what level of integration each of its locations has achieved.[15]

15 **Colorado Behavioral Healthcare Council Integrated Care Mapping Project**;

4.0 Privacy and Data Implications for Each Level of Integrated Care

How a behavioral health program is designed and what that means for deploying behavioral health staff within a CHC can determine whether the more stringent substance use treatment regulations (42 C.F.R. Part 2) apply to the organization and staff. However, even if 42 C.F.R. Part 2 doesn't apply, there are cases at all levels of integration where a CHC will be receiving 42 C.F.R. Part 2 protected data, and therefore care must be taken in how that information is stored, who can access the information, and whether it can be re-disclosed.

Coordinated Care (Levels 1 and 2)

Using the model of integration introduced in section three of this report, levels 1 and 2 involve (at a distance) collaboration between primary care and behavioral health providers and staff. This is mostly so that there is awareness of medications and diagnoses, and to ensure that the treatment at the CHC takes into account , as much as possible, the mental health or substance abuse disorder treatment the patient is receiving and vice versa. For instance, if a PCP realizes that a patient is involved in an intensive outpatient therapy program through a mental health clinic, it may be unrealistic to counsel the client to begin a radical diet change to help control their diabetes. Likewise, enabling the mental health clinic to be aware that the patient's diabetic condition has become acute could enable that staff to better support the client.

Release of Information

At levels 1 and 2 of integration, providers rely on clinical notes to be exchanged through their Electronic Health Record (EHR) systems so that, at the point of care, they can make informed treatment choices and ensure that there are minimal adverse effects with other treatments the patient may be receiving. In order to begin the flow of information from a behavioral health clinic, especially one that considers itself a 42 C.F.R. Part 2 program, the CHC must have the patient authorize the CHC to receive their health information from the 42 C.F.R. Part 2 program using a 42 C.F.R. Part 2 compliant release of information (ROI) form.[16] Most 42 C.F.R. Part 2 governed entities prefer to use their own forms. For this reason, the most common workflow is to have the patient complete an ROI that authorizes the release of, at the very least, their medications, and diagnosis and treatment summaries.

The challenge with this workflow is that it puts the burden on the patient to remember to enact the ROI, and with the myriad of other issues most patients are working with, this task often doesn't get completed. As a workaround, some CHCs keep hard copies of ROIs from the behavioral health organizations that they collaborate with so that the patient can be asked to complete the ROI as part of the check in/check out process. One issue with this workflow is that there is no automated way to keep the releases current with updated patient information. Considering this, CHCs may end up using obsolete forms that will not be accepted by the behavioral health clinic, causing a delay in the process of exchange.

16 Legal Action Center; http://lac.org/wp-content/uploads/2014/12/Sample_Form_1.pdf

In Michigan, the Department of Health and Human Services, has stepped in with a solution they hope will help. That department has created a standard, behavioral health consent form which, while not mandating its use, does require behavioral health organizations to accept the form.[17]

Receiving and Storing Behavioral Health Information

There are three main ways that a CHC could receive clinical notes from another facility:

1. **Fax / Scan**: The first is via fax or mail. For many CHCs this is the primary way that information is received. In most cases, fax and paper records are then scanned and added to a separate external documents section of the EHR (if one exists). In order for discrete information from these documents, such as medication, diagnosis and other treatment details to be available within separate sections of the EHR, they must be manually entered and are often indicated as coming from an invalidated or external source.

2. **Secure Email**: Another method some CHCs use to receive external clinical documentation is via attachment to a secure email (such as Direct[18,19]). In some cases, the documents attached to the email are simple PDF files which are stored similar to how scanned documents would be. In more sophisticated exchanges, the documents are in a standard document format called a Continuity of Care Document (CCD). These documents, frequently delivered directly into the EHR (often via Direct e-mail), have the ability to be parsed such that the discrete data elements from the CCD (for example, medications, problem list, allergies, etc.) are automatically stored in discrete data fields within the EHR.

3. **Health Information Exchange**: The final way that CHCs may receive information from external sources is via a connection to a health information exchange (HIE). HIEs often provide a routing service where they automatically forward critical clinical documents, as they are received into the HIE, to providers who are indicated as having a treating relationship with the client. For example, if upon admission to the hospital, a patient indicates that the PCP at the CHC is their treating provider, the hospital notes could then be automatically routed and ingested by the CHCs EHR (if the practice is integrated with the HIE).

In Colorado, Quality Health Network (one of two HIEs' in the State) recently began to route behavioral health documents to CHCs and other providers using an automated routing method. Once the infrastructure is setup to enable the HIE to receive both behavioral health and CHC documents, two additional steps must be completed: First, the patient must indicate, at the behavioral health organization, that they give their consent for their data to be shared with the CHC; second, both the CHC and the Behavioral Health Center need to be indicated (within the HIE) as having a treating relationship with the client. Once those two steps are accomplished, every time that patient is seen by a behavioral health practitioner, the treatment note is automatically routed for review within the CHC EHR and vice versa with services the patient receives at the CHC.

17 http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_58005-343686--,00.html

18 Direct – or *direct exchange* – is a basic type of health information exchange (HIE) that allows a health care provider to securely send patient information directly to another specified health care provider, or even a patient.

19 National Learning Consortium, HealthIT.gov; https://www.healthit.gov/sites/default/files/directbasicsforprovidersqa_05092014.pdf

Prohibition Against Re-disclosure of 42 CFR Part 2 Information:

Any data (whether in document form or entered discretely) obtained from a 42 C.F.R. Part 2 entity should not be stored in the EHR if there is a chance that this information could be re-released to another entity without patient authorization. 42 C.F.R. Part 2, subsection 2.32 requires the following notice to accompany any information disclosed by a Part 2 program:

> *This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*[20]

When a CHC receives information that includes the above disclaimer, it is incumbent on them to follow the above prohibition against re-disclosure, unless they obtain the patient's consent. Therefore, many CHCs that receive 42 C.F.R. part 2 information – whether electronically or via fax / mail – choose to keep these documents in a separate, sequestered part of their EHR, and also choose not to enter the discrete information into discrete fields within their EHR. Once EHR vendors improve their technology such that discrete data, along with the source of that data and/or the sensitivity level of the data can be stored and referenced, this will be the best course of action.

Bottom Line: When receiving health information from a 42 C.F.R. Part 2 provider, it is best not to store this information within the main clinical sections of the EHR unless it can be designated as sensitive. Since many EHRs do not have this capability, it is best to keep this information in document form separate from the main EHR system. This will make it easier to protect against inadvertent re-disclosure when information is released from the CHC EHR.

Co-located Care (Levels 3 and 4)

At the third and fourth levels of integration, CHCs often begin to offer some level of behavioral health services within their clinics. In one example, a federally qualified health center (FQHC) began to place staff from the local Community Mental Health Center (CMHC) within their treatment clinics. In this case, the staff are not employed by the FQHC, but are contracted from the CMHC. These two entities have chosen to share information by having the contracted CMHC staff enter their encounter notes directly into the FQHC's Electronic Health Record (EHR) system. However, since the CMHC considers itself a 42 CFR Part 2 program, patient consent must first be obtained before documenting services in this way. In order to streamline this process, all patients - upon entering the waiting area of the clinic where these co-located services are being rendered - are provided with an educational pamphlet about the integrated care program. They are then asked by the front desk staff to sign a Release of Information form authorizing the behavioral health staff to "release" information gathered during their visit to the FQHC. The patient's consent (or decline of consent) is updated in the FQHC's EHR and accessible by the CMHC staff so they can appropriately determine whether entering their chart notes into the FQHC's EHR has been authorized by the client. One reason that the FQHC prefers this method of data entry is that they bill payers directly for the behavioral health services rendered within their clinic. Therefore, in order to bill for these encounters, they need to have them

20 42 C.F.R. § 2.32

entered into their EHR. The FQHC then has an agreement to pay a monthly contracted rate to the CMHC for their staff services.

In the case of this integration example, the behavioral health services rendered by CMHC staff within the FQHC clinic are non-acute, brief interventions. If a patient requires more intensive services (for example, drug or alcohol rehab services) they are referred to the CMHC for treatment. Until the patient receives this more intensive treatment at the CMHC, the CMHC is not interested in including the documentation of encounters at the FQHC in their own EHR.

Qualified Services Organization Agreement (QSOA)

When practices use contract staff agencies that consider themselves covered by 42 C.F.R. Part 2, direct entry into the CHC EHR is often considered a form of disclosure from a Part 2 entity. Therefore, in order to enable such disclosure, the patient must authorize the release of their information into the CHC EHR. Or the Part 2 entity can enter into a Qualified Services Organization Agreement (QSOA)[21] with the CHC. Since we've already explored the Release of Information process and what is required in that circumstance, we will look more closely at what disclosure looks like when two agencies enter into a QSOA.

A QSOA[22] is very much like the 42 C.F.R. Part 2 equivalent of a HIPAA business associates agreement. It enables the 42 C.F.R. Part 2 entity to partner with a non-42 C.F.R. Part 2 organization (CHC) that is providing services (for example, physical health care or administrative oversight) to patients of the 42 C.F.R. Part 2 program. A key component of the QSOA is that the CHC is fully bound by Part 2 as if it were a Part 2 program itself. The following is an excerpt from SAMHSA's FAQs clarifying in what circumstances Part 2 information can be disclosed without consent:

> *Part 2 requires the QSO to agree in writing that in receiving, storing, processing, or otherwise dealing with any information from the program about patients, it is fully bound by Part 2, it will resist, in judicial proceedings if necessary, any efforts to obtain access to information pertaining to patients except as permitted by Part 2, and will use appropriate safeguards to prevent the unauthorized use or disclosure of the protected information [42 C.F.R. § 2.11]. In addition, QSOAs may allow disclosure in certain circumstances.*[23]

Bottom line: When a CHC decides to contract with staff from a behavioral health organization, it is important to understand whether the behavioral health organization considers its entire operations covered by 42 C.F.R. Part 2 or only a program within the organization as covered. If the entity considers its entire operations covered by 42 C.F.R. part 2, either obtaining authorization from the patient via a ROI or entering into a QSOA may be necessary. If the behavioral health organization considers only certain programs within the organization to be covered, and the staff being contracted do not exclusively work within that program and do not exclusively provide substance abuse treatment diagnosis, treatment and referral, then a ROI or QSOA may not be required. As always, it's important to seek legal guidance before entering into this type of contractual agreement.

21 42 C.F.R. § 2.11

22 Legal Action Center; **http://lac.org/wp-content/uploads/2014/12/Sample_Form_6.pdf**

23 **http://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs** - Question 6

Integrated Care (Levels 5 and 6)

As a CHC begins to offer care at levels five and six, they often also begin to hire their own behavioral health staff since much of the integration work at these levels involves the move to team based care. As we've discussed earlier, simply hiring a behavioral health treatment provider does not automatically require a CHC to follow 42 C.F.R. Part 2 rules. In fact, as we've seen, as long as the CHC is not creating a program or hiring a provider to primarily deliver substance abuse diagnosis, treatment, or referral services, 42 C.F.R. Part 2 will most likely not apply.

However, keep in mind that although the Federal 42 C.F.R. Part 2 regulations may not apply, many states do have more stringent requirements for documentation pertaining to mental health and/or substance use treatment services. For this reason, selecting an EHR that has the capability to segregate sensitive behavioral health information from more widely distributable physical health information will be an important consideration. Currently, there are only a handful of vendors that offer an EHR product that can handle physical and behavioral health information, and workflows equally well. A few vendors that currently offer separate behavioral and physical health products have begun integrating them into a cohesive platform. Other vendors with EHRs that focused on either the behavioral health or CHC markets are expanding their products to enable charting of information from the other modality. However, since most CHCs have already made a profound investment in their EHRs, switching out an EHR platform in order to provide a higher level of integrated care is not always feasible or desirable.

Separate EHRs - Shared Care Plan

One of the cornerstones of an organization that has successfully achieved Level 6 integration is the ability of that organization to generate and maintain a care plan that details both behavioral and physical health interventions and treatments in one comprehensive plan. That plan is then referenced by providers and patients alike to constantly guide treatment and determine if outcomes are being achieved. In cases where the organization is maintaining separate EHRs for behavioral and physical health treatment, this can be a challenging milestone to achieve.

However, one organization in southwestern Colorado (that is self-assessed as being a level six integrated facility) has devised a unique way of bridging the gap in EHR technology. Axis Healthcare started as a community mental health center in 1960, serving mental health and substance use treatment needs of residents of five counties in southwest Colorado. In 2013, they applied for – and successfully were awarded – FQHC status and added a full suite of primary and specialty care services at two integrated clinics (La Plata Integrated and Cortez Integrated Healthcare). Rather than deploy a new EHR system capable of handling both physical health and behavioral health encounters and billing, the organization decided to continue operating with two EHRs, but began development of a shared "care plan" application that was accessible by all providers.

Health Information Exchange (HIE)

Axis Health Care and other CHCs that follow suit can have the best of both worlds; an EHR that matches clinical workflow, and a separate tool that integrates the data to provide a much needed shared view into the total picture of the client. In many ways, this is the function provided by many HIEs and other regionally-based health care collaboratives. The challenge with many of these regional solutions is that they have not yet cracked the code of how to include 42 C.F.R. Part 2 data within their exchanges easily. The fact is that when a CHC hires their own staff—even if that staff is specifically designated to provide substance abuse treatment—a release is not required to share

information within the entity itself. Therefore, solutions at the level of the CHC for shared care plans (like the one Axis Health Systems is using) do not need to factor in the complexities of patient managed consent to release.

To enact regionally-based care (whether through an HIE or care coordination tool that is regionally hosted), some type of patient managed consent is required. One way that a number of HIEs are handling this is to:

1) Enter into QSOAs with the 42 C.F.R. Part 2 entities, allowing the HIE to receive and store the protected information without patient consent.

2) When a provider requests access to any patient information within the HIE, that provider must first obtain patient consent.

3) The HIE then requires the provider to attest that they have the required consent on file before releasing the sensitive information.

The Kansas HIE, KHIN, adopted this type of a solution in 2015. KHIN created a statewide release of information form that enables the patient to give access to their sensitive records housed at KHIN for a single day.[24] Then, upon attesting that they have that signature on file, KHIN releases the information to that provider for viewing purposes only just for that day.

Other HIEs are enacting similar systems except that the patient consent is actually completed within the infrastructure of HIE so that it can be available on an ongoing basis to inform whether a patient's information can be released or not.

In 2013, the Prince George's County Maryland Health Department launched a pilot of a patient managed consent exchange with a 42 C.F.R. Part 2 provider. After a consent policy is created at the HIE, the software shares information, such as medical summaries, to authorized providers while filtering out sensitive information the patient does not wish to share.

Similarly, the Colorado Regional Health Information Organization (CORHIO), one of two HIEs in Colorado, plans to launch a pilot of a patient mediated consent solution in summer 2016. Once successfully completed, CORHIO hopes to offer the consent database as a service to other entities so that patients can manage their consent for all of the health collaboratives.

Care Coordination

The above examples of patient directed consent-based exchange are exciting, but still fall short of providing a true collaborative care solution needed for CHCs to achieve level 5 and 6 integration. For that reason, many population health and care coordination tools that provide functions such as shared care plans and specific coordination functionality are also beginning to adopt similar patient managed consent functionality.

24 http://www.khinonline.org/images/Patient_Consent_for_Point_of_Care_Disclosure.pdf

Bottom Line: When a CHC hires their own staff, they have much more access and ability to share and leverage the behavioral health treatment information to create a truly integrated experience. Operationally, however, very few EHR products are sophisticated enough to provide that level of integration within a single product. As a result, some CHCs are designing their own data repositories that siphon data from their physical health EHR and behavioral health EHR into a common platform from which an integrated care plan can be utilized. HIEs and regionally-based care collaboratives, because they attempt to aggregate data across a number of healthcare entities, must take on the added task of managing patient consent and enacting the sharing of sensitive data within the guidelines provided by each patient. Unless 42 C.F.R. Part 2 is updated to remove the consent provision (all indications are that this will not happen), creating solutions that include patient consent on how their sensitive data can be treated is a reality that is here to stay.

5.0 Federal and State laws Concerning the Exchange of Behavioral Health Data

One obstacle that many CHCs need to overcome as they begin integrating behavioral health care is how to establish technologies and policies for dealing with the more sensitive data that will now become part of their EHR. While this issue is present for providers who are at levels 1 and 2 on the continuum, many already have policies about receiving and storing records provided by external sources in such a way that the information is available – but not part of – the patient's health record. Therefore, receiving sensitive behavioral health records would simply fall into this general use case and be sequestered separately in the EHR. However, as practices move along the continuum to level 3 and beyond, they increasingly need the patient's full record available and integrated within the EHR for treatment planning, alerts and notifications, and analytics/population health. Maintaining this information in a separate, document based section of the EHR is no longer practical.

Not only is the protection of this sensitive data within the EHR a courtesy, there are also legal regulations that govern how a practice must manage, and in some cases not re-disclose, this sensitive data. Generally, there are three regulations that impose requirements on the use and disclosure of protected health information[25] (PHI): (1) The Health Insurance Portability and Accountability Act of 1996 (HIPAA), (2) the federal substance abuse treatment regulations administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) called 42 C.F.R. Part 2 and (3) state health information exchange laws.

HIPAA

HIPAA, as most CHCs are aware, defines any personally identifying information such as name, social security number, medical record number, etc. as protected health information (PHI), and dictates in which cases this patient identifying information can be disclosed. Among other reasons, PHI can be disclosed, without patient consent, for purposes of treatment, payment and operations. While this applies to all modalities of treatment (physical health, mental health, substance abuse treatment, etc.), HIPAA goes on to specify that psychotherapy notes (notes captured by the clinician during a therapy session) can only be disclosed with patient consent. It is important to point out that a summary document of an encounter – even an encounter for behavioral health services – is not considered a psychotherapy note. Since the introduction of HIPAA, it has become common practice for behavioral health clinicians to NOT include notes regarding the details of a therapy session in the EHR to support, among other things, HIPAA exchange of behavioral health care summaries. Therefore, these summaries of care (also known as Continuity of Care documents) are generally sharable without consent as long as state law is not more restrictive in this matter.

25 45 Code of Federal Regulations § 160.103

42 Code of Federal Regulations (C.F.R.) Part 2

42 C.F.R. Part 2 regulations, on the other hand, are generally more stringent than HIPAA about treatment records that are created, transmitted and maintained by federally assisted drug and alcohol abuse programs.[26] In general, these regulations prohibit the use and disclosure of substance abuse treatment information unless the individual has consented to disclosure, to a specific entity, outside of the program. Whether a CHC is a "federally assisted drug and alcohol abuse program" and therefore subject to 42 C.F.R. Part 2 is, of course, a priority decision for a CHC to make as they integrate more behavioral health services within their treatment offerings.

To aid with this decision, below are a few guidelines for consideration that, if applicable, would warrant further legal research as to whether a CHC would need to comply with 42 C.F.R. Part 2. In order to be considered a 42 C.F.R. Part 2 Entity/Program/Individual, the federally assisted requirement, and one of the three below designations, would need to apply:

1. **Receives federal funds in any form (even if not used for drug/alcohol services), or is authorized, licensed, certified, registered by the federal government (for instance, non-profit designation)**[27]

   Analysis: Most CHCs would fall into the 42 C.F.R. Part 2 definition of being federally assisted. Even those not operating under tax-exempt status would qualify if they receive Medicaid or Medicare reimbursements. Generally, this is a catchall and very few facilities would fall outside of this designation.

AND

2. **Individual or entity, other than general medical facility, that holds itself out as providing, and does provide, drug/alcohol diagnosis, treatment, or referral for treatment**.

   Analysis: Typically a CHC would not fall into this category, as most CHCs are considered a general medical facility. In most cases, only individual providers or facilities whose entire suite of services are focused on substance abuse treatment would be identified by this category.

OR

3. **An identified unit within a general medical facility which holds itself out as providing, and does provide, drug/alcohol diagnosis, treatment, or referral for treatment**.

   Analysis: Only if a CHC offers a specific program within their facility focused on substance abuse treatment – and holds itself out as providing this treatment – would this category apply. While the regulations do not specifically define the phrase "holds itself out", SAMHSA provides additional guidance on interpretation of the regulations in a Frequently Asked Questions (FAQ) document.[28] The following are some examples from the FAQ of what it would mean for a program to hold itself out as providing substance abuse treatment services:

26 42 Code .of Federal Regulations§ 2.12

27 http://lac.org/wp-content/uploads/2014/07/Final-LAC-Slides-for-JBS-Webinar-09-19-2013.pdf

28 http://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs - Question 10

> "The phrase 'holds itself out' is not defined in the regulations, but could mean a number of things, including but not limited to state licensing procedures, advertising or the posting of notices in the offices, certifications in addiction medicine, listings in registries, internet statements, consultation activities for non-program practitioners, information presented to patients or their families, or any activity that would lead one to reasonably conclude that the provider is providing or provides alcohol or drug abuse diagnosis, treatment or referral for treatment."[19]

OR

4. **Medical personnel or other staff in a general medical care facility whose primary function is the provision of drug/alcohol diagnosis, treatment, or referral for treatment, and who are identified as such**.

Analysis: In order for this category to apply, the CHC must hire someone for the purpose of providing substance abuse diagnosis, treatment or referral for treatment. To make this clearer, let's take an example from a webinar provided by the Legal Action Center[29] to help multi-use medical facilities (such as CHCs) to determine how 42 C.F.R. Part 2 applies to them:

> *"Dr. O'Neill is an addiction specialist working in a community health center that provides all types of health care (e.g., primary care, geriatric care, OB/GYN). Dr. O'Neill treats the community health center's patients who have substance use disorders, and prescribes buprenorphine for opiate addiction as part of her practice.*
>
> *Dr. O'Neill is covered by 42 C.F.R. Part 2 because she is a medical provider in a general medical care facility whose primary function is the provision of drug/alcohol diagnosis, treatment, or referral for treatment, and who is identified as such. She is 'federally assisted' because she must have DEA registration to prescribe buprenorphine."*

However, let's modify the above example and say that Dr. O'Neill does **not** provide substance use treatment, but instead conducts assessments with each of her patients to determine if they have a substance use issue; if they do, she refers them out for treatment. In this case, would Dr. O'Neill still be considered a 42 C.F.R. Part 2 provider? The answer is no since Dr. O'Neill does not provide the actual treatment and is only assessing patients' substance use. Some people are confused by this because Dr. O'Neill is referring patients for treatment and, on the surface, this seems like one of the requirements in this category. However, the definition states that this must be Dr. O'Neill's primary function which it is not; her primary function is the delivery of general health services.

The above example would hold true if the CHC contracted with, or hired, a behavioral health professional to conduct screenings, brief therapy and referrals at the CHC. Unless that provider's primary function is to provide drug/alcohol diagnosis, treatment, and referral, this category would not apply.

29 Legal Action Center "Patient Privacy & Confidentiality for SBIRT Providers" Webinar (07/2014)

State Law

Each state has a number of statutes governing medical record confidentiality. In particular, each has statutes specifically governing some aspect of mental health records, and most have laws governing substance abuse records. The coverage and requirements of these laws vary widely, however.[30] While a thorough analysis of all State's laws is beyond the scope of this paper, we offer the following general guidance from how Colorado has modified and clarified several statutes and regulations to bring sharing of behavioral health information more in line with Federal HIPAA and 42 C.F.R. Part 2 regulations:

1. **Licensure**: Most states have laws, rules and/or policies that license and regulate mental health and substance abuse treatment providers. Along with ethical standards, these regulations govern how patient information is collected, stored, and disseminated. In Colorado, the Division of Regulatory Affairs (DORA) held a state statute that required licensed mental health workers to obtain consent before releasing any information on their clients. That regulation was modified in 2011 so that these licensed professionals could release mental health information so long as they complied with Federal regulations. The way the statute was amended was to add the following language to the end of the statue (Title 12 Article 43-218: Disclosure of confidential communications):

   > *(6) This section does not apply to covered entities, their business associates, or health oversight agencies, as each is defined in the federal "Health Insurance Portability and Accountability Act of 1996", as amended by the federal "Health Information Technology for Economic and Clinical Health Act", and the respective implementing regulations.*

2. **Behavioral Health Authority**: Most states, through their department of health and human services, have departments whose role is policy development, service provision and coordination, program monitoring and evaluation, and administrative oversight for the public behavioral health system. Frequently, as part of the administrative oversight, these organizations have policies which behavioral health facilities must comply with in order to maintain their licensure. In Colorado, this office is called the Office of Behavioral Health (OBH) and falls under the Colorado Department of Health and Human Services. Although CHCs do not fall into the jurisdiction of this authority, CHCs often hire staff from organizations under regulation by these authorities. Therefore, it is helpful for CHCs to be familiar with the record keeping and privacy requirements that staff from these regulated facilities will be required to follow. In Colorado in 2013, the Office of Behavioral Health consolidated eight volumes of rules to one as part of a streamlining effort. They also added language to their regulations to reinforce that HIPAA and 42 C.F.R. Part 2 are the operative regulations that need to be followed when exchanging patient information.

We've explored how the federal HIPAA and 42 C.F.R. Part 2 regulations may affect information capture, storage and exchange at CHCs, and also offered some guidance on how a CHC can obtain more information on state laws. A common question at this point is which regulation does one follow when there is not uniform agreement? The answer is to always follow the guidance that gives patients more privacy protections which, in many cases, will be 42 C.F.R. Part 2. It is for this reason that many community mental health facilities that are beholden to HIPAA, 42 C.F.R. Part 2 and State regulations often default to following 42 C.F.R. Part 2. It is far better, in their minds, to comply with the regulation that affords maximum protection than to have to operationalize a variety of policies that enable varying degrees of information collection and exchange.

30 http://www.ncbi.nlm.nih.gov/books/NBK19829/

6.0 Conclusion

As we have explored, integration of behavioral health services within a CHC is an exciting opportunity to bring whole person health into the mainstream of service delivery. As payers move away from transaction based payment methods, to methods that reward providers for improving the overall health of the patient's they treat, integrated care will not only make sense in terms of the right care strategy, but will become one that is financially sustainable as well. When a patient's anxiety, depression or substance use are managed and symptoms controlled, that patient has the capacity to manage difficult physical health symptoms. When we support the entire person, we see improvement in all areas of their life and that is what population health is all about.

However, designing an integrated program that wisely takes into account the policy and technological strategies for skillful integration can be the difference between a program with stellar outcomes and one that simply adds cost and complexity into an already costly and complex care environment. This paper has hopefully illuminated a path forward –one that can be achieved without the need to overhaul the entire workflow and technological infrastructure already in place. Utilizing the services of a HIE can bring great benefit to the CHC looking to coordinate or co-locate service offerings with their behavioral health partners. Working with, or creating, local care collaboratives that provide care coordination or population health tools to the full set of care providers within the community can provide access to tools that a CHC may not otherwise be able to afford. These care coordination tools are also a way that practices striving for full integration (level 5 and 6) can provide truly integrated technical infrastructure, while maintaining separate EHRs for behavioral health and physical health services.

As with most innovation, the path forward is not well defined, nor does one path fit for all organizations. However, many pioneers have been delivering integrated care within a CHC environment for many years and improving their offerings over time. Most centers are willing to share what they have learned through webinars or simply responding to personal requests for conversations. Eventually, we will no longer need to use the term "integrated care" because this will simply be the standard by which care will be delivered. At that point, we will see marked improvement in the health and lives of everyone served by the healthcare system.