



**National Association of State Mental Health Program Directors**

**Crossing the Behavioral Health  
Digital Divide:**

**The Role of Health Information Technology in Improving Care  
for People with Behavioral Health Conditions in  
State Behavioral Health Systems**

**By**

**JOEL E. MILLER**

**Executive Director and Chief Executive Officer  
American Mental Health Counselors Association**

**ROBERT W. GLOVER, PH.D.**

**Executive Director  
National Association of State Mental Health Program Directors**

**STUART YAEL GORDON, J.D.**

**Director, Policy and Health Care Reform  
National Association of State Mental Health Program Directors**

**May 2014**

**Alexandria, Virginia**

**Fourth in a Series of Eight on ACA Implementation**

**This issue brief was sponsored by NASMHPD and the  
Substance Abuse and Mental Health Services Administration (SAMHSA)**

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## Executive Summary

Behavioral health providers continue to confront a number of barriers to their effective use of health information technology (HIT) as a means to integrate, and increase the quality of, behavioral health care. Perhaps the most significant barriers are federal and state statutory and regulatory electronic health information privacy restrictions and provider misunderstandings or ignorance of those restrictions. But before legal restrictions can even become an issue, providers are limited by financial and technological barriers from participating in the electronic health information system infrastructure.

The capital costs of purchasing and installing HIT hardware and software, and training staff on that technology, remain significant for behavioral health providers—especially sole practitioners and those in small practices—as well as for State Behavioral Health Agencies (SBHAs) facing continuing budget shortfalls. While a wide range of “eligible professionals” and hospitals were given access to federal bonuses for developing a meaningful use of electronic health records and HIT for years 2011 through 2016 by the American Recovery and Investment Act of 2009 (ARRA),<sup>1</sup> the legislation failed to include behavioral health providers among those eligible for the incentives. As a result, many behavioral health providers have lagged in their adoption of HIT to enable them to link to and integrate with primary care practitioners and other specialty providers. As a direct result of this limited interaction with the behavioral health field, non-behavioral health providers have, in the absence of market demand, faced a lack of development of electronic screening and clinical support tools that would help them to screen for behavioral health conditions and recognize behavioral health conditions inter-related to comorbid physical medical conditions they treat. And as non-behavioral health providers continue to move ahead in the adoption of HIT, they will likely leave behavioral health providers further behind, making it ever less likely that e-integration can ever occur.

While recognizing that the Substance Abuse and Mental Health Services Administration (SAMHSA) and its federal and private partners have taken many concrete steps to further behavioral health HIT integration, this issue brief suggests a number of additional activities that stakeholders at the federal and state level can undertake to accelerate the process, including:

- asking Congress to amend the ARRA to make meaningful use incentives available to behavioral health providers participating in the Medicaid and Medicare programs;
- clarifying how behavioral health providers might be otherwise indirectly eligible for those incentives;
- partnering with private nonprofit health organizations to obtain funding to offset the capital costs of adopting electronic technologies;
- revising federal and state regulatory restrictions on provider re-disclosures of patient substance use treatment information;
- implementing provider education programs to clarify what those restrictions do and do not entail;
- working with HIT technology vendors to seek development and dissemination of electronic screening and clinical decisions support tools for behavioral health providers and primary care providers treating patients with the potential for having behavioral health conditions that impact their physical co-morbidities; and
- educating consumers regarding the benefits of having providers share their electronic health information while still abiding by patient privacy concerns.

## I. Introduction

The burden of behavioral health conditions (including mental health disorders and substance abuse) in the U.S. remains great. Approximately 18 percent of Americans 18 years of age or older—42.5 million adults—suffer from a diagnosable mental disorder in any given year.<sup>ii</sup> Forty-six percent of U.S. adults will experience some mental disorder during the course of their lifetime.<sup>iii</sup> The estimated lifetime prevalence of mental health disorders among the U.S. adult population is 31.2 percent for anxiety disorders, 25 percent for impulse-control disorders, 21.4 percent for mood disorders, and 15 percent for substance use disorders.<sup>iv</sup> Depression is among the leading global causes of life-years lived with a disability.<sup>v</sup>

The inter-relatedness of mental illness and chronic disease and their respective risk factors, is similarly striking. Mental illness is a source of significant co-morbidity in the chronically ill, particularly for patients with diabetes or cardiovascular disease. For example, diabetes patients are twice as likely to suffer from depression as the general population. Mental illness is also associated with a higher prevalence of substance abuse.

A substantial percentage of behavioral health care is delivered in primary care settings. In 2012, nearly 34 percent of consumers with a primary mental health diagnosis were cared for by general and internal medicine physicians. Given the burden of illness and the volume of behavioral health care delivered in primary care settings, better integration between behavioral health and primary care is needed. Health Information Technology (HIT)—including Electronic Health Records (EHRs), Personal Health Records (PHRs), Health Information Exchanges (HIEs), and smartphone health applications—can be a key facilitator of this integration.

Behavioral health stakeholders are largely supportive of information-sharing to improve patient care. The sharing of patient information among treating providers facilitates care coordination, and helps reveal physical comorbidities that could be leading to or exacerbating behavioral health conditions, or vice versa. However, for behavioral health care clients and providers, there are significant obstacles to achieving the levels of quality, coordination, and effectiveness derived by primary care providers and their patients from the use of HIT. Many behavioral health care practices and clinicians lack interoperable (communication and linkages) information systems. The availability of financial resources for them to invest in and maintain HIT systems is limited and most are ineligible for the provider financial incentives made available through the Medicare and Medicaid EHR meaningful use incentive payment programs. In addition, the privacy laws that apply to behavioral health data—particularly the restrictions on disclosing substance use treatment information under 42 C.F.R. Part 2—are more complex than those applicable to general patient information, and EHRs do not typically conform to these additional privacy safeguards. HIEs struggle with how to manage the patient consent requirements for behavioral health—and especially substance use treatment—patient data disclosure. To aid in the integration of behavioral health and primary care using health IT, both EHR vendors and HIEs will need to find ways to ensure their systems include the necessary functionality to support information-sharing while complying with federal and state privacy protections.

Key questions addressed in this report will include:

- What HIT capabilities do behavioral health and primary care providers need to better support integration across care settings?

- What HIT capabilities do behavioral health care providers need to support current care practices? To support team-based, patient-centered approaches to care?
- What are the different needs inherent in specific care settings (mental health, substance abuse treatment facility, residential, out-patient, criminal justice, social work, etc.)?

## II. Health Information Technology (HIT) and Public Mental Health

Persons with serious mental illness (SMI) experience high levels of co-morbid health conditions and die up to 25 years sooner than the general population.<sup>vi</sup> The benefits of integrating personal behavioral health data with personal health data can be great, facilitating care coordination and provider recognition of inter-related behavioral health and physical health conditions. Appropriate policies and practices permitting the sharing of behavioral health data while protecting the confidentiality and privacy of personal health information can be very effective in producing positive patient outcomes.

However, recent federal enactments that have had a major impact on the promotion of HIT have failed to address the needs of mental health and substance abuse care providers. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) Provisions of the American Recovery and Reinvestment Act of 2009,<sup>vii</sup> authorized approximately \$20 billion for the payment of Medicare and Medicaid program incentive bonuses to physicians, hospitals, and other health providers who adopt electronic health records. In addition, the HITECH ACT included millions in funding for the implementation of HIEs designed to enable providers to share their EHR data and thereby better coordinate and improve care. Unfortunately, mental health and substance abuse treatment providers were not included in the categories of providers eligible to receive EHR incentives, which were primarily limited to hospitals and providers falling within the definition of “physician” under §1861(f) of the Social Security Act.<sup>viii</sup> As a result, in many states, behavioral health providers have not been active participants in adopting EHRs or HIT.

The expansion of health coverage under the Affordable Care Act (ACA) of 2010 will change the financing of mental health and substance abuse services and thereby greatly expand the number of individuals with mental health and substance abuse disorders who will now have insurance coverage for treatment. The ACA pushes to improve patient outcomes through the development and enhancement of Accountable Care Organizations (ACOs) and Health Homes (Medical Homes) as well as by making prevention and wellness programs available without patient cost-sharing to give service recipients more control over their own care. Nevertheless, the ability to share data essential to facilitating improved patient outcomes will likely be impeded by a lack of access for mental health and substance use treatment providers to HIT and related EHR initiatives.

As states braid funding streams and methodologies, agencies should work together to incorporate behavioral health into the design, implementation, and use of EHR and HIEs, in order to share data and improve outcomes and accountability, while eliminating redundancy and administrative burden in reporting. Where state leaders have failed to include behavioral health providers in strategizing and planning health information systems to this point, strong leadership by federal agencies and SBHAs is needed to ensure that health systems reach out to behavioral health leaders to work in concert in developing integrated or at least fully interoperable and accessible health records and systems. If mental health providers are unable to implement EHRs or share information with primary care providers, and if state and local mental health authorities are not included in planning for HIE, critical information from the mental health system will either not be fully included or have the ability to

be integrated as primary care moves to electronic data-sharing.

Without the development of HIEs that can accept electronic personal mental health data from mental health providers while meeting all of the requirements of the Health Insurance Portability and Accountability Act (HIPAA)<sup>ix</sup>, 42 United States Code § 290ee-3, Title 42, Part 2 of the Code of Federal Regulations, and other applicable regulations and statutes, even those providers that are able to implement EHRs will be unable to truly meet the HITECH Act's "meaningful use" criteria regarding the sharing of electronic data. Mental health entities will be unable to effectively utilize any electronic personal health data that might help them to coordinate care between and among state psychiatric hospitals and community mental health centers (CMHCs), state psychiatric hospitals and general hospitals and emergency departments, CMHCs and primary care physicians, or any other complex linkages critical to increasing integration and improving care.

As a result, coordination between behavioral health and primary care providers via the sharing of electronic personal health data may lag behind coordination within the rest of the health care continuum. Even absent the enactment of federal legislation making Medicaid and Medicare incentive payments available to behavioral health providers, the Department of Health and Human Services (HHS) could still greatly assist mental health systems by providing training and technical assistance on how to utilize Medicaid and Medicare funds to implement the use of EHRs and thereby assure that personal mental health information is not excluded from HIEs and EHRs.

If mental health systems could find a way to implement and utilize EHRs in parallel service delivery systems, HHS could access extracts of de-identified clinical data from those HIEs to obtain outcomes and information about services funded under Substance Abuse and Mental Health Services Administration (SAMHSA) block grants and other HHS funding streams. By aggregating de-identified personal health information, HHS could potentially eliminate its current reliance on separate lagging administrative reporting systems from state mental health and substance use treatment agencies and providers and instead tap into a more timely and detailed source of clinical and outcomes data, producing greater agency flexibility to react more quickly to impending behavioral health issues with public health initiatives and best evidence practices.

### **III. Behavioral Health, Health IT, and State Medicaid Programs**

Behavioral health conditions, including both mental health and substance abuse conditions, are among the most significant cost-drivers for state Medicaid programs, both because of the costs of directly providing behavioral health care and the costs of treating co-occurring physical conditions. In fact, behavioral health issues rarely occur in isolation; individuals with behavioral health conditions often have a range of other physical conditions, many of which are expensive chronic conditions such as heart disease and diabetes.

Behavioral health conditions influence how a patient receives care in any setting. Individuals often are treated for depression and anxiety in primary care settings, while more costly residential or in-patient mental health facilities and substance abuse facilities cater to those with severe mental health issues and substance abuse problems. Some of those facilities—smaller facilities with fewer than 16 beds not subject to the prohibition against Medicaid reimbursement to Institutions for Mental Disorders (IMDs) under § 1905(a)(B) of the Social Security Act<sup>x</sup>—are state-run and operate almost solely with Medicaid revenue while others receive little or no financing from Medicaid. With Medicaid enrollment increasing as a consequence of the Affordable Care Act, state Medicaid program behavioral health costs are expected to grow accordingly.

In the publicly financed health care system, including Medicaid, there is often a lack of coordination between behavioral health providers and primary care doctors, hospitals, and other specialty providers. Providers offering behavioral health services include managed care organizations (MCOs), private practices, and community health centers. That fragmentation may exacerbate health and social problems for behavioral health patients, and undermine efforts to improve overall health outcomes.

HIT has been long recognized as a means to reduce fragmentation in care. EHRs facilitate coordination among all of a patient's providers, and help providers recognize where there may be inter-related physical comorbidities and behavioral health conditions. Yet behavioral health providers have been limited in the ability to access those important tools for integration.

#### **IV. Electronic Health Records' Information System Implementation**

In a 2012 NASMHPD Research Institute (NRI) survey, over half of the SBHAs responding reported they either have an operating EHR system or are currently installing an EHR system in their state psychiatric hospitals. In addition, many community mental health providers are implementing their own EHR systems. A recent Commonwealth Fund study found that 93 percent of Federally Qualified Health Centers (FQHCs) now have a functioning EHR system.<sup>xi</sup> SBHAs have indicated they could use assistance to ensure the EHR systems they purchase meet future HIE (data exchange) standards and emerging federal standards for the meaningful use of EHRs. Mental health providers have also indicated a need to learn how to best implement and utilize EHRs and determine how they might qualify for future funding for their staff psychiatrists and other physicians.

Although the HITECH Act provided about \$20 billion in Medicaid and Medicare incentive payments to health providers to subsidize and reward their implementation of EHRs, psychiatric hospitals and community mental health centers were not designated as eligible to receive federal funds. Although HHS has funded HIT Regional Extension Centers to work with providers on the implementation and utilization of EHRs, in many states SBHAs do not appear to be a focus of the Centers.

Officials from the HHS Office of the National Coordinator (ONC) have suggested in public meetings that while an SBHA may not be eligible for the Medicaid and Medicare incentive payments, individual psychiatrists and nurse practitioners employed by the agency might be able to apply for incentive payments for their individual professional services. However, the ONC has not provided subsequent clarification of exactly how this reimbursement could be accomplished, or the potential amounts that mental health providers could receive in incentive payments. Mental health providers need to know not only if this is a viable approach to support EHR incentives, but also that the size of any potential reimbursements would warrant pursuing this approach.

#### **V. State Health Information Exchanges**

About \$564 million has been distributed to states and qualified State Designated Entities (SDEs) to facilitate the creation of health information exchanges (HIEs) at the state level.<sup>xii</sup> An additional \$375 million was distributed to non-profit organizations to support the development of 52 regional extension centers (RECs) designed to aid health professionals in the adoption and meaningful use of EHRs. As of July 2013, more than 147,000 providers were enrolled with a Regional Extension Center. Of these, more than 124,000 were utilizing an EHR and more than 70,000 providers had demonstrated the Meaningful Use of EHRs, as required under the ARRA.<sup>xiii</sup>

A July 2010 HHS Program Information Notice (PIN), entitled “Requirements and Recommendations for the State Health Information Exchange Cooperative Agreement Program,” mandated that states and SDEs outline in their State Strategic and Operational Plans (state plans) a concrete and operationally feasible plan to enable e-prescribing, the receipt of structured lab results, and the sharing of patient care summaries across unaffiliated organizations. States and SDEs were required to use their authority, programs, and resources to: (1) initiate a transparent multi-stakeholder process; (2) monitor and track meaningful use HIE capabilities in the state; (3) assure trust of information sharing; (4) set strategy to meet gaps in HIE capabilities for meaningful use; (5) ensure consistency with national policies and standards; and (6) align with Medicaid and public health programs.

The PIN further indicated that each state HIT Coordinator “should” coordinate HIT efforts with Medicaid, public health, and other federally funded state programs such as agencies on aging. However, despite the inclusion of behavioral health in the list of services that HIEs should address, many SBHAs report they and state substance abuse authorities have not been included in their state’s HIE activities. In 2009 when HHS first announced state grants to develop HIEs, only one SBHA had received any commitment of funds (\$10,000) from the \$564 million in HHS’s HIE grant funds to states.

The NASMHPD Research Institute’s (NRI’s) SBHA Profiles System has been compiling information on the involvement of SBHAs in state HIE activities since 2011. Results for 2013 reveal that less than one-quarter of 52 SBHAs that have implemented an EHR are electronically sharing their data with their state’s psychiatric hospitals and community health centers through an HIE. SBHAs have reported that concerns about confidentiality and privacy rules for mental health and substance abuse are leading to the exclusion of the SBHA from HIE activities. Where information is shared, the consumer is being asked to provide prior consent. Although a frequently cited concern is the federal Substance Abuse privacy rule at Title 42, Part 2 of the Code of Federal Regulations, with one mental health commissioner describing the regulations as “antiquated” and another as “discriminatory”. SBHAs generally believe that sharing behavioral health EHR information with HIEs is possible technologically and procedurally using a standard consumer consent for release of information form that thoroughly informs the consumer that his or her behavioral health information will be shared with the HIE. Unfortunately, some SBHAs have not even had the opportunity to resolve these confidentiality issues since they are not active participants in their states’ HIE initiative.

In addition, some SBHAs have been told that since specialty providers do not qualify for the federal HITECH Act’s EHR incentive payments for “meaningful use”, their programs are judged by the state HIE to be a lower priority than meeting the needs of health providers receiving the stimulus incentive payments. Exclusion from participation in HIE planning activities has prevented SBHAs from weighing in on issues such as patient privacy.

A longer term goal regarding data measuring services and outcomes has to be for HHS to devote resources to facilitate the use of clinical behavioral health data in HIEs and EHRs in generating outcomes reports useful in monitoring the performance of mental health systems. Over the next decade, general health care will move to a system where existing administrative reporting systems are seen as duplicative, burdensome, and ultimately unnecessary as higher quality clinical data sets of outcome measures and performance indicators are able to be extracted from EHRs and HIEs. If mental health is precluded from HIEs because of funding limitations, exclusion from design and implementation, and exclusion from incentives, the mental health system could become a stigmatized separate system with poorer quality data and an inability to coordinate with the primary health care system. As a result, providers may be unable to recognize patient comorbid medical conditions causing behavioral health conditions, or behavioral health medications contributing to or causing adverse physical reactions.



## VI. Areas of Focus for Behavioral Health and Primary Care Integration Using Health Information Technology

Creating integrated health care systems that include behavioral health is challenging, but an important effort for states to undertake in seeking better patient outcomes and lower costs. Many of the most costly and complex patients have multiple physical conditions in addition to behavioral health issues. The co-occurrence of a behavioral health condition in patients with the most common chronic physical conditions, including asthma, coronary heart disease, hypertension, diabetes, or congestive heart failure, is associated with health care costs that are 60 to 75 percent higher than those without a mental illness. Adults with a behavioral health condition and a chronic physical condition have higher rates of hospitalization, ranging from 46 percent higher for congestive heart failure to more than 70 percent higher for hypertension.

Integration of behavioral health and primary care has been a focus area for federal agencies, behavioral health professional associations, and other stakeholders for almost a decade. A May 2014 Commonwealth Fund report found that 53 percent of FQHCs are pursuing the integration of behavioral health services.<sup>xiv</sup> The ACA includes initiatives such as person-centered health homes and primary and behavioral health integration grants. These initiatives have renewed the focus on care coordination between primary care and behavioral health providers.

In the preceding sections, we have highlighted steps the federal government should take to facilitate and improve the use of HIT by mental health stakeholders. In this section, we suggest three specific areas in the delivery of care in which HIT will be critically important to better integrating behavioral health and primary care: care coordination, patient engagement, and medication management.

### Care Coordination through HIT

Health care providers routinely exchange information about patients they share. Through HIE, the ability of a patient's care team to share data during transitions of care can be made more efficient and standardized. The need for care coordination to improve patient outcomes and lower costs is highly relevant to behavioral health clients. The standardization of a Continuity of Care Document (CCD) in electronic format allows a more efficient, effective, and complete transition of care information between treating providers. SAMHSA has been leading efforts to develop standards and recommendations about what data to include in CCDs shared by behavioral health providers, through the international standards development organization Health Level 7 (HL7). EHRs and HIT tools support collaboration between primary care and behavioral health providers, enabling care teams to track client progress over time and to identify patients with poor outcomes for intervention through enhanced clinical data summaries.

SAMHSA has been active prescribing best practice guidelines on the use of HIT to support integration of behavioral health and primary care. The SAMHSA-Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions (CIHS) worked with the National eHealth Collaborative to explore the [Current State of Sharing Behavioral Health Information in Health Information Exchanges](#). The collaborative created a final [report](#)<sup>xv</sup> that outlines challenges and opportunities for integrated primary and behavioral health care providers participating in an HIE and shares case studies from 11 states, reaching the conclusion that the inclusion of behavioral health information on HIEs will allow for more effective community-based and state-based planning. The case studies review the participation of both primary care and behavioral health providers in CIHS-assisted HIE initiatives in Illinois, Kentucky, Maine, Oklahoma, and Rhode Island, as well as other initiatives in Colorado, Michigan, Nebraska, New

York, Ohio, and Texas — each at different stages of HIE implementation. The case studies offer practical advice, and the full report can be a resource for providers looking to establish or participate in an HIE in their state.

It is also important to learn from organizations such as FQHCs and patient-centered health homes that may have already implemented evidence-based, peer-reviewed care coordination practices and tools developed by organizations such as the National Center for Quality Assurance (NCQA) and endorsed by the National Quality Forum (NQF). Partnerships between federal agencies such as the Health Resources and Services Administration (HRSA) and the Centers for Medicare and Medicaid Services (CMS), soliciting feedback from the field can also provide insight into best practices and potential challenges of coordinated care relative to behavioral health.

## **The Barriers Created by 42 CFR Part 2**

HIEs can be used to support a community-wide record, including data from criminal justice, housing and urban development, and other social support systems. 42 CFR Part 2 requires patient consent to share substance abuse treatment information and prohibits re-disclosure of this information without consent. Compliance is a significant concern to the behavioral health provider community. However, primary care providers and technology vendors may be unaware of these regulations and the legal obligations involved in receiving substance abuse treatment data. Currently, most primary care EHR systems do not have the capacity to manage consents or to control the re-disclosure of select types of information. Informing primary care providers and organizations and HIE system vendors on the proper protocols for receiving, storing, and managing behavioral health data electronically would facilitate care coordination. EHR vendors need explicit instructions and clear definitions on how to treat data. Guidance related to the development of a community-wide record would be useful.

Health information privacy is already a prominent issue of high priority for both ONC and SAMHSA. Within the Standards & Interoperability Framework, ONC has a Data Segmentation for Privacy Initiative through which SAMHSA and the Veterans Administration are piloting approaches to data segmentation and granular consent management that should help solve these issues.

There are a number of areas to be addressed:

- How to comply with federal health information privacy laws;
- How to determine the chain of responsibility for following up with patients when a patient does not make it to a referral appointment; and
- Sharing sensitive information through dashboards, storage, and access to psychotherapy notes, referral management, liability issues, etc.

## **Clinical Decision Support Tools**

Integrated care requires the use of standard behavioral health screening and assessment tools, delivery of treatments, and evaluation of progress across care settings. [Clinical Decision Support](#) provides clinicians, staff, patients or other individuals in primary care settings with knowledge and person-specific information, filtered or presented at appropriate times, to enhance health and health care. CDS uses a variety of HIT tools to enhance decision-making in the clinical workflow, including: computerized alerts and reminders to care providers and patients, clinical guidelines, condition-specific order sets, focused patient data reports and summaries, documentation templates, diagnostic support, and contextually relevant reference information.

CDS tools related to behavioral health and electronic screening are needed in primary care settings to initially identify a behavioral health risk or condition, and in behavioral health settings to track a patient's progress and outcomes. In addition, there is a need for CDS tools focusing on medication-assisted treatment of behavioral health disorders. CDS must include treatment recommendations based on screening results to provide clinicians with options for treatment in a primary care setting and recommendations about when to instead refer to specialty care.

The SAMHSA draft Strategic Plan for 2015-2018, [\*SAMHSA Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015–2018\*](#),<sup>xvi</sup> identifies support for the dissemination of evidence-based clinical decision support tools for behavioral health as agency Objective 5.4.4.

### What is “Meaningful Use” in e-Behavioral Health?

Whether or not Medicaid and Medicare incentive payments can be expanded to behavioral health providers, there is a need to expand the use of performance measures for electronic behavioral health screening and treatment by primary care and other providers in the Medicaid/Medicare “meaningful use” incentive program. Evidence-based performance measures about appropriate use of behavioral health risk assessments can be taken from those measures already developed by professional societies or other organizations and endorsed by the National Quality Forum (NQF). In tandem with CDS tools, these measures would optimize care coordination by ensuring appropriate behavioral health screening and treatment are received, particularly by patients with comorbid chronic conditions.

### Consumer (Patient) Engagement

The recent widespread use of the term *patient engagement* reflects a cultural shift towards patient-centeredness in health care, where patients are seen as equal partners in their care and respected as experts in their own health experience. Patient engagement is the active sharing of information and decision-making with patients to help them understand diagnoses and treatment options, select those options that best meet their goals, and manage their self-care.

A number of state Medicaid programs have begun integrating self-directed care into their behavioral health programs. States have the option of implementing self-directed services under § 1915(c) waiver programs, or the § 1915(i) or (k) State Plan Options. States can also authorize self-direction of personal assistance services under § 1915(j), authorized under the ACA. States such as [Florida](#), [New Jersey](#), and [Texas](#) have either implemented self-directed care within their Medicaid programs or are in the process of doing so.

An important cornerstone of patient engagement is patient-provider communication, with the bidirectional sharing of information and dialog between patient and provider facilitating patients playing an active role in their own care. Strong patient-provider communication has been associated with improved patient comprehension and retention of information, increased patient satisfaction, increased compliance, reduced anxiety, and improved treatment outcomes.

Inherent challenges and limitations make progress in incorporating behavioral health care into state HIE efforts difficult, but careful planning, informed by sister states' experiences and strategies, can increase the chance that tangible returns and system efficiencies are realized. The case studies and guidance provided in this report are intended to suggest next steps to serve as a road map for SBHA commissioners as they plan HIT strategies and develop collaborative partnerships.

## Medication Management, Adherence, and Abuse

Medication regimens increase in complexity as comorbidities increase, requiring comprehensive review and reconciliation. Medication non-adherence is a significant problem in patients with behavioral health disorders. Promoting medication adherence may greatly improve health outcomes by ensuring that maintenance drugs requiring continuing consumption have their intended effect, and by avoiding harmful interactions between prescribed drugs and/or with self-prescribed over-the-counter medications. Promoting medication adherence and aligned monitoring will also ensure that adverse physical and psychological reactions can be appropriately treated where they occur or avoided entirely.

Medication management refers to the standards of care that ensure patients' medications are assessed to determine their appropriateness, effectiveness, and safety for patients' medical conditions. Effective medication management requires an individualized care plan in which patients understand and actively participate to optimize treatment outcomes.

Medication management can be broadened to include adherence to non-pharmacological treatments important to behavioral health outcomes as well as pharmaceutical treatments. However, concerns about privacy laws and regulations can present barriers to sharing information about what behavioral health regimens are relevant, and create difficulties when transitioning between care providers and care settings. Overcoming barriers to information-sharing is critical to developing a more effective, broader approach to treatment adherence.

### **VII. Identified Barriers in Behavioral Health/State HIE Integration and Potential Solutions**

As states attempt to implement a strategy for incorporating behavioral health care facilities into existing state HIE efforts, they may find that funds are insufficient for the task. Additionally, because behavioral health providers and facilities are largely ineligible for incentive payments under meaningful use guidelines, persuading providers to invest in and use those systems may be challenging.

Further, behavioral health care is often frequently segmented from the rest of the health care system, with care often provided to patients in specialized facilities that are isolated from the rest of the health care system. The behavioral health care system is also fragmented within itself. Fragmented funding mechanisms often required a mix of state, local, private and federal funds that make it difficult to maintain consistent financial incentives to encourage HIT adoption.

States may consider exploring a mix of funding sources that offer chances for states to develop a range of technology tools in behavioral health. For instance, states that receive grants from CMS to implement a health home could emphasize HIT's role in helping patients to develop an individual care plan for behavioral health issues and coordinating with other providers. Nebraska has developed an information system tailored to interact with the behavioral health treatment system which became operational in Spring 2011. The system, called the Electronic Behavioral Health Information Network (eBHIN). eBHIN connects providers who participate in the statewide HIE by connecting to the Nebraska Health Information Initiative (NeHII). The project has relied on a mix of mostly federal funds, including several grants from the Agency for Healthcare Research and Quality (AHRQ), a Rural Health Network Development Grant from HRSA, and funds from Region V Systems and the Nebraska Information Technology Commission.

The Nebraska model also relies in part on fees paid by providers. Recognizing the financial burden for

providers in adopting EHR systems, the Nebraska model includes subsidies for the costs associated with implementing the system and participating in statewide HIE. The participation fees are initially reduced and will increase incrementally over a period of five years.

### **Engaging Public and Private Payers and Leveraging Purchasing Strength**

Payers analyzing expenditures are quick to recognize that services and claims related to behavioral health are among the top five expenses. Similarly, the co-occurrence of mental health and physical conditions demands careful coordination of care and care transitions. States should engage private payers, large employers, and business coalitions in developing policies that encourage greater integration of behavioral health and HIE. Developing payment incentives across the public and private spectrum can magnify the effect and encourage integration of behavioral health with HIE efforts.

States may also want to consider leveraging their role as major purchasers of health care services—through Medicaid and state employee benefit programs—to specify that behavioral health information technology be a requirement in provider networks and contracts. A payer-driven model may be found in integrated health care systems such as Kaiser Permanente, which has invested heavily in web-based functionalities so that physicians, hospitals, and health plan administration can easily connect and coordinate care delivery. Systems such as Kaiser Permanente’s emphasize a continuum of care and include EHRs, e-prescribing, case management software, and clinical guidelines.

### **Involvement with Other Health IT Efforts in the State**

The ONC has several existing grant programs in operation in every state. Regional Extension Centers and Beacon Communities each have a variety of activities with specific care delivery focal points. State HIT coordinators should reach out to ONC programs in their state to identify opportunities to leverage behavioral health efforts that may be underway or already in place.

In addition, reaching community providers is an important step in deploying HIT systems across the delivery system, particularly in behavioral health, which relies heavily on local services. Innovative outreach strategies may be necessary to encourage adoption and use.

**The Oregon Community Health Information Network (OCHIN)** is a non-profit collaborative of community health centers with a combined database of nearly 1 million individual patients throughout seven states. OCHIN serves as the lead partner in Oregon’s Regional Extension Center and provides practice management and electronic medical records software and services to community-based clinics. The network has pioneered the development of comprehensive HIT systems, including behavioral and dental health functionalities that enable providers to take an integrated approach to diagnosis and treatment. OCHIN has accomplished that by developing a common health record for federally qualified health centers and hospitals, and fostering collaborations between county health departments and community health centers to enable them to buy a high quality health software package.

**New York is using a community-based and provider-centric approach** to behavioral HIT. The Health Care Efficiency and Affordability Law (HEAL), passed in New York in 2004, supports projects to accelerate the adoption of HIT and interoperable electronic health records. Phase 17 of HEAL awarded \$120 million to community-based HIT projects to build a more streamlined approach to sharing patient information, with a focus on behavioral health and long-term care. One of the HEAL 17 initiatives allows the Regional Extension Adoption Center for Health (REACH) to create a new division of the extension center dedicated exclusively to behavioral health providers. The proposed project will utilize NYC REACH's existing HIT and interoperability infrastructure to facilitate health information

exchange between designated mental health providers and existing patient-centered medical home-qualified practices.

## Privacy and Consent

As noted previously, navigating patient consent regulations poses a major challenge. In any medical practice area, careful consideration must be given to creating a balance between protecting consumers' sensitive health information and enabling appropriate provider access to electronic health information. In the case of behavioral health and substance abuse, the unauthorized disclosure of sensitive personal health information can be particularly critical because of the stigma attached to mental illness and the possible legal entanglements related to substance abuse.

State laws may create even greater restrictions on re-disclosure of medically sensitive information, including behavioral health information, than under 42 CFR Part 2. State and territorial laws vary in the extent and under what conditions medically sensitive information such as treatment for substance use can be shared. Sharing information across state lines creates additional challenges and complexity to clinical information exchange. Differences across states raise questions about which state's laws hold in a given situation, causing providers to be reluctant to participate in information exchange.

While health information network plans typically promote features that allow patients to opt-out for general (non-specially protected) health information and opt-in for specially protected categories of health information, some states are exploring the feasibility of statutory changes to allow for a full opt-out consent model. States seek products that offer capabilities that allow sensitive health information to remain visible to authorized providers and invisible to other viewers. Targeted educational campaigns for providers may encourage adoption and use. The HHS "Privacy and Security Framework for Electronic Exchange of Individually Identifiable Health Information" puts forth principles to guide health information exchanges, and includes the tenets of "openness and transparency" and "individual choice."

SAMHSA is also committed to sharing strategies for HIT implementation among states, and can offer lessons in incrementally aligning data processes with long-term health system coordination goals. SAMHSA views the deployment of HIT to support the treatment of substance abuse and behavioral health problems as a strategic initiative and priority, and has been actively involved in creating affordable, accessible, and standardized clinical medical records through open source software. While there is an added benefit to open source software in its ability to structure consistent privacy standards across all users, legal requirements for privacy are still evolving, and interoperability has not been established.

## VIII. Case Studies in Integration: What's Working? What are the HIE Challenges?

### Case Study #1: DePelchin Children's Center

#### Integration of Specialty Care with Mental Health

Physicians at the University of Texas Health Science Center at Houston (UTHSC) Pediatric Specialty Clinics recognized that, for a majority of families, chronic pediatric illness is accompanied by a variety of psychosocial factors that impact the ultimate success or failure of medical interventions. Specifically, they found that mental health issues can interfere with patients' medical progress and that the children's families may need therapeutic assistance to be able to cope with the demands associated with chronic illness and create a home environment supportive of the children's medical treatment goals.

UTHSC approached DePelchin Children's Center (one of the largest, most comprehensive providers of children's mental health, foster care, and adoption services in Texas) to offer mental health services that complement medical health care offered in select pediatric specialty clinics. Using a grant from the SAMHSA, DePelchin is working with UTHSC to provide mental health services in several specialty clinics such as the Weight Management Clinic, the Infectious Diseases (HIV) Clinic, the Care (Child Abuse) Clinic, and the Endocrinology Clinic.

Under the program, DePelchin provides initial assessments and ongoing treatment sessions in each of the UTHSC Clinics as well as some additional follow-up sessions at DePelchin's main clinical outpatient location. The preliminary reports from the physicians in these clinics show improved medical outcomes from patients receiving the mental health intervention. In addition to the positive health impacts for patients, these integrated services are projected to provide a net savings from improved patient adherence to treatment goals.

Despite the benefits of these integrated mental and medical health services, technological barriers need to be conquered to realize the full potential of the collaboration. For example, DePelchin and UTHSC each utilize their own electronic health record (EHR) systems to document services provided to patients. A combined record is not possible with the current systems because the clinical documentation for mental health services is vastly different than for specialized medical health counterparts. Clinical data from these disparate information systems is not easily integrated to inform providers on both sides of care on patient progress, and coordinating access to the other organization's system is logistically difficult—as well as inefficient. While the expected outcomes are positive, they are difficult to substantiate, since data must be manually correlated and this impedes effective program evaluation.

The implementation of a health information exchange (HIE) that eliminates data fragmentation by seamlessly integrating patient information between the two entities and across the various specialty practices would greatly aid the collaboration. The HIE would also help facilitate an increased integration of care that maximizes the value benefit.

## Case Study #2: Barber National Institute

### Challenges of IT Funding for Special Needs Educational Programs

Schools and educational centers in Pennsylvania and across the country struggle with managing the continued investment demands/challenges for needed IT infrastructure. Many organizations are facing deep cuts in the federal and state reimbursement for services. These reductions have made it increasingly apparent that organizations need to seek funds from granting organizations to support emerging technologies that facilitate the sharing of client-specific information across the enterprise.

The Barber National Institute (BNI) was established in 1952 to provide educational services to children and adults with developmental disabilities. Since then, BNI has grown into a multi-faceted organization that provides a complete range of services to individuals with special needs, including early intervention for infants and toddlers, an inclusive preschool, state-of-the-art diagnosis and treatment for autism, an approved private school, job training and placement, residential options including community group homes, life sharing and supported living programs, in-home services, specialized therapies and behavioral therapy, a creative arts program, and a retirement center.

Services are provided to more than 3,600 individuals at facilities and group homes located in Erie, Pittsburgh, and Philadelphia, Pennsylvania. More than 2,000 staff members are committed to providing the highest quality education and care with respect, compassion, and encouragement. As a community services organization, BNI accepts most medical insurance, but receives the majority of its funding through state and federal agencies.

### Investing in Information Technology

BNI has a long history of investing in technology, and implemented its first electronic clinical records system in 1997. In 2010, the system was replaced with a more robust clinical system providing a comprehensive EMR. Currently, care delivery staff who work at remote sites throughout the state utilize approximately 275 netbooks with remote access.

Funded through donations of individuals and businesses, iPads, iPod Touch, and Tapit Interactive boards has been incorporated into classrooms in traditional subjects such as math and reading, as well as in building communication and social skills. In May 2012, BNI announced a collaborative project with Notre Dame evaluating whether or not the use of interactive robots in therapy would help children with autism develop social and communication skills.

However, while the deployment of technology to facilitate treatment and therapies flourishes, the required investment in technologies to support the entire enterprise has not kept up with growth. Acquisition for expansion of state-wide internet and communication networks and internal wireless networks has become a challenge. Public-private partnerships with organizations like the Gates Foundation could be part of the answer.

SAMHSA is also working to make resources more readily available to consumers electronically. [SAMHSA's Disaster Mobile App](#) offers disaster-related behavioral health resources. The agency's Suicide Safe Mobile App, due to be released in January 2015 for Apple and Android mobile devices, will be equipped to:

- enable users to download the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) card for use offline;



- provide interactive sample cases;
- access information, including patient educational materials, crisis hotline wallet cards, fact sheets, and treatment and other supportive resources; and
- browse conversation starters that provide sample language and tips for talking with patients about suicidal ideation; and
- use SAMHSA's Behavioral Health Treatment Services Locator to provide timely patient referrals.

## Case Study #3: New York State – Process Improvement Program

### Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)

The Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) is a portfolio of HIPAA-compliant web-based applications that provide access to administrative health data (including Medicaid data) to support clinical decision-making and quality improvement. PSYCKES was developed by a multidisciplinary in-house team at the New York State Office of Mental Health and is currently implemented in over 400 programs across New York State, including emergency departments, inpatient units and outpatient programs.

Medicaid is a primary payer of mental health services. It has been estimated that 67 percent of individuals with schizophrenia utilize Medicaid services for their care.<sup>xvii</sup> Medicaid enrollees represent a diverse and multiply-disadvantaged population that may be particularly vulnerable to poor outcomes. Medicaid data represents a largely untapped resource to support clinical decision-making and quality improvement.

PSYCKES aggregates large volumes of Medicaid data to produce user-friendly reports for patients, clinicians, and health care managers. Reports, updated monthly, summarize Medicaid data for individual clients across treatment settings and over time. Up to 70-100 pages of Medicaid claims and encounter data can be summarized in a one- to two-page report that can be printed or downloaded as a PDF or Excel spreadsheet and copied into an EMR. The report includes:

- A graph of all services over time, highlighting gaps in service engagement, medication adherence, and use of emergency and hospital services;
- Medication trials, with links to patient education materials;
- Rapid identification of medication adherence and service engagement challenges, and their relationship to inpatient utilization;
- A visual representation of service patterns, including outpatient services, emergency and inpatient services, dental and ophthalmological services, labs and procedures, and residential services;
- Clinical summaries of integration and coordination of care across service settings statewide that allow behavioral health providers to identify and track medical diagnoses and treatment;
- Flagging of quality concerns;
- Intake evaluation and ongoing treatment monitoring; and
- Patient engagement and education.

PSYCKES quality reports also summarize performance on a number of quality measures, including measures related to psychotropic medications and hospital utilization for both behavioral health and medical reasons. PSYCKES also facilitates benchmarking and comparisons with regional and state peer groups for different service setting types or patient characteristics.

### PSYCKES as a Tool to Support Quality Improvement

New York State Office of Mental Health has used PSYCKES as a tool to support several statewide quality collaboratives. Projects have focused on:

- Reducing psychotropic poly-pharmacy, particularly among youth;
- Reducing the use of higher metabolic impact antipsychotics among individuals with existing

cardio-metabolic conditions including obesity, hypertension, hyperlipidemia, diabetes and ischemic vascular disease; and

- Reducing higher than recommended dosing.

Other projects include reducing hospital re-admissions, health promotion, and improving care coordination.

Significant reductions in the prevalence of quality concerns have been observed. The first statewide PSCYKES QI Medicaid Project had 343 participating clinics. Participating clinics reached the target reduction of 30 percent reduction. As of December 2011, clinics reported changing the medication regimens of 7,355 consumers so that they no longer met criteria for the selected indicator set, representing 32 percent of positive cases identified in PSCYKES at baseline across participating clinics statewide. The monthly QI data reported by participating clinics was mirrored in Medicaid data analysis, which showed an associated 2.9 million dollars in attributable savings in pharmacy costs in the first year.

## Case Study #4: Centerstone Recovery-Oriented System of Care for Substance Abuse Goes Online

In 2010, Centerstone, the nation's largest not-for-profit provider of community-based behavioral health care, received a grant from SAMSHA to adopt and refine a new model of service delivery for substance abuse called the Recovery-Oriented System of Care (ROSC). Recovery-oriented systems of care are networks of organizations, agencies, and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders.

The initial program was offered by Centerstone of Indiana to the community around Bloomington. After about 18 months, the program showed significant improvements in the number of participants served (from about 200 inpatient participants to about 4,200 participants with a range of inpatient and outpatient services including, including employment and housing supports, recovery coaching, and service inquiries, as well as individual and group support services. While there were a number of early indicators of the success of the ROSC program, one key measure stood out: for one group of participants recently released from prison, the rate of recidivism dropped by about 50 percent, from an estimated 25 percent to about 12 percent.

Services were largely limited to those who could get to the Recovery Engagement Center. This meant that those with transportation limits—particularly those in the rural community around Bloomington—had a lower level of engagement, relying to some degree on direct telephone conversations along with physical meetings at the facility. In the fall of 2011, Centerstone received a grant from SAMSHA to extend the ROSC by creating a “virtual Recovery Engagement Center,” or “v-REC.” The v-REC uses HIT, including social media and online clinical tools, linked to Centerstone's EMRs and EHRs, to improve the efficiency of communication between recovery coaches and participants and lower barriers for those seeking care. The first phase, including a public website with links to resources, moderated chat, and other features for the recovery community, went live in June 2012. Phase 2, including online clinical tools (such as health risk assessment, recovery plan, periodic update, personal calendar, and secure message center) was launched in July 2012.

In November 2013, Centerstone received a three-year, \$840,000 grant from SAMHSA to implement an e-ROSC modeled after the Indiana e-ROSC for more than 150 individuals living in underserved rural areas in Tennessee and southern Kentucky. Additionally, grant funding is being used to support the development of a mobile platform that will enable Centerstone clients to easily access information about their health record directly from a mobile device. Clients will be able to schedule appointments, ask questions about their treatment plan, and have information about helpful community resources at their fingertips.

## IX. Recommendations for Future Action by All Stakeholders

### Action Steps for State Behavioral Health Agencies (SBHAs)

Connecting behavioral and physical health records may present a significant opportunity for community providers and health systems to develop a continuum of prevention, intervention, treatment, and support, share clinical information, and advance integrated and patient-centered care. While national standards and capacity for HIT and HIE are evolving, and while efforts to forge a fully-integrated health care system continue, there are several actions states can take to lay a foundation for progress.

1. **Stakeholder Involvement in State Roadmaps for Full Integration.** SBHAs can convene and connect key stakeholders, such as behavioral health agencies, Medicaid programs, payers, provider groups, and patient advocates to develop a roadmap for full integration of behavioral health within their state's HIE. SBHAs can charge convened groups with identifying cases that would benefit from additional automation or standardization, and developing priorities for key initiatives that support system efficiencies, clinical decision support, and evidence-based guidelines. The state HIT Coordinator should help to coordinate this activity.
2. **States and SBHAs can use their purchasing power to specify that integration of behavioral health information in the state HIE be a requirement in provider networks** and contracts for Medicaid managed care and state employee benefit programs.
3. **SBHAs can work with stakeholders to develop educational opportunities for providers and consumers to clarify the value of including behavioral health information in health information exchanges** and to improve understanding of the laws affecting the sharing of behavioral health information.
4. **To engage patients, SBHAs should work with provider groups to educate patients about their privacy rights and the implications of sharing information.** Clear and simple terms may be needed to translate complicated medical terminology. Patient advocates have highlighted the need to show patients clear examples that will help them understand to what they are consenting. Patient engagement should also include family and caregivers.
5. **SBHAs should provide guidance on the impact of and practices for incorporating patient-generated health data (PGHD) into EHRs.** PGHD includes information patients share about their symptoms, health behaviors, treatment adherence and side effects, physiological states, and disease progression outside of a clinical setting. Some organizations have successfully implemented patient-centered tools, such as medication symptom trackers and patient journals, for purposes of communicating PGHD.
6. **SBHAs should promote the development of HIT systems as a means to facilitate peer support.** Peer support services are a key component of behavioral health services and person-centered recovery. Systems that can support information-sharing with members of the patient's recovery or support team who are not a part of the medical establishment have a great potential to advance behavioral health outcomes.

## Action Steps for the Federal Government to Take to Facilitate Behavioral Health Access to HIT

The federal government should be encouraged to take the following actions to facilitate access by behavioral health providers to HIT:

1. **HHS should clarify the potential for psychiatrists and other qualified behavioral health providers to become eligible for incentive payments for the meaningful use of EHRs** when employed as medical staff by or contracted with entities that are designated eligible professionals or eligible hospitals under existing statutory authority. If behavioral health providers are, indeed, considered eligible under those circumstances, HHS should sponsor training sessions for SBHAs and mental health providers on how to access the incentive payments for the meaningful use of EHRs. At the same time, HHS should seek to obtain Congressional authorization for EHR meaningful use incentives for all behavioral health providers, regardless of site of care or employment relationship with eligible professionals or eligible hospitals. If behavioral health providers are eligible or if expanded authorization is enacted, CMS should provide further technical assistance to SBHAs and state Medicaid agencies, using funding for Medicaid Information Technology Architecture (MITA) and other CMS Information Technology funding, on modifying HIT systems to meet behavioral health needs.
2. **SAMHSA and HHS, including the ONC, should continue to share best practices that promote the development, implementation, and use of EHRs in behavioral health settings.** Many behavioral health providers and SBHAs are concerned that the implementation of EHRs can be expensive and complicated. State experts that have already made the transformation can serve as consultants in providing assistance for SBHAs and behavioral health providers. Clinical advantages should be emphasized to combat the perspective that the implementation and use of EHRs is merely an “IT” issue. HIT Regional Extension Centers should ensure they address behavioral health EHR issues and include SBHAs and local provider agency representation in their target populations.
3. **HHS should work with states to educate primary care stakeholders about federal behavioral health privacy regulations.** Informing primary care providers and organizations and HIE system vendors on the proper protocols for receiving, storing, and managing behavioral health data electronically would facilitate care coordination. EHR vendors need explicit instructions and clear definitions on how to treat data. Guidance related to the development of a community-wide record would be useful.
4. **HHS should address the apparent misunderstanding by some state HIEs that CFR Title 42, Part 2 limits the inclusion of mental health providers in HIEs and the sharing of substance abuse data for patients with dual diagnoses of mental illness and substance abuse.** HHS and SAMHSA should develop models or examples of the appropriate client consent agreements for sharing behavioral health patient-level data with HIEs, and descriptions of technology safeguards that can be used. HHS should also develop models, case studies, and training for SBHAs on how SBHAs with varying state statutes governing confidentiality have successfully negotiated a relationship with the state HIE entity.
5. **SAMHSA should encourage technology vendors to develop and disseminate evidence-based Clinical Decision Support (CDS) tools for behavioral health screening and treatment, as identified in the “SAMHSA 2.0” agency strategic plan for 2015-2018.**

6. **HHS should promote the development of standards for electronic behavioral health screening tools.** Many standard assessment tools exist for a given purpose (e.g., screening for alcohol use). Additional guidance and standards for the selection of validated tools, the incorporation of those tools, and the coding and exchange of related data would be useful. However, while standards may be necessary to successfully exchange data, mandating the use of a specific screening instrument may limit the ability of providers to select tools that they prefer and to develop new, innovative approaches to screening.

A solution could be to develop standards for the endorsement of validated tools and standard processes for calibrating tools to a single standard scale. This approach would preserve provider choice and flexibility to select instruments that best meet care needs as the field evolves. A significant amount of work assessing and developing reliable, valid screening instruments has already been completed, and is available through the Agency for Healthcare Research and Quality's Web site (<http://www.ahrq.gov/research/mentalix.htm>).

Evidence-based performance measures of appropriate use of behavioral health risk assessments have already been developed by professional societies or other organizations, and endorsed by the National Quality Forum (NQF). In tandem with CDS tools, these measures would optimize care coordination by ensuring appropriate behavioral health screening and treatment are received, particularly by patients with comorbid conditions.

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<sup>i</sup> Title IV of Pub. L. No. 111-5 (enacted February 17, 2009).

<sup>ii</sup> The NSDUH Report: State Estimates of Adult Mental Illness from the 2011 and 2012 National Surveys on Drug Use and Health, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, U.S. Department of Health and Human Services (February 2014), last accessed at: <http://www.samhsa.gov/data/NSDUH.aspx>.

<sup>iii</sup> Kessler, R.C. et al, "Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication," *Arch Gen Psychiatry* (July 2005).

<sup>iv</sup> Behavioral Health, United States, 2012, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, U.S. Department of Health and Human Services (2013), last accessed at <http://www.samhsa.gov/data/2012BehavioralHealthUS/2012-BHUS.pdf>.

<sup>v</sup> Ferrari AJ, et al., "Burden of Depressive Disorders by Country, Sex, Age, and Year: Findings from the Global Burden of Disease Study 2010," *PLoS Med* 10(11) (November 2013).

<sup>vi</sup> Parks, Joseph, MD. Et al., "Morbidity and Mortality in People with Serious Mental Illness," National Association of State Mental Health Program Directors Medical Directors Council (October 2006).

<sup>vii</sup> Division A, Title XIII and Division B, Title IV, Pub. L. No. 111-5 (2009).

<sup>viii</sup> 42 U.S.C. §1395x(r).

<sup>ix</sup> Pub. L No. 104-191(1996), codified at 42 U.S.C. § 300gg and 29 U.S.C § 1181 et seq. and 42 USC 1320d et seq.

<sup>x</sup> 42 U.S.C. 1396d(a).

<sup>xi</sup> Ryan, Jamie. et al., "The Adoption and Use of Information Technology by Community Health Centers, 2009-2013, Commonwealth Fund (May 2014).

<sup>xii</sup> "HITECH Programs and Advisory Committees, State Health Information Exchange, State Health Information Exchange Cooperative Agreement Program," last accessed at <http://www.healthit.gov/policy-researchers-implementers/state-health-information-exchange>.

<sup>xiii</sup> "RECs At A Glance," last accessed at <http://www.healthit.gov/providers-professionals/regional-extension-centers-recs>.

<sup>xiv</sup> Abrams, M. et al., "Ready or Not? How Community Health Centers View Their Preparedness to Care for Newly Insured Patients," Commonwealth Fund (May 2014).

<sup>xv</sup> National E-Health Collaborative, *The Current State of Sharing Behavioral Health Information in Health Information Exchanges* (September 2014).

<sup>xvi</sup> Substance Abuse and Mental Health Services Administration, "SAMHSA Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018" (draft [released for stakeholder comment July 27, 2014](#)).

<sup>xvii</sup> Elizabeth Khaykin, Ph.D., M.H.S et al., "Health Insurance Coverage among Persons with Schizophrenia in the United States," *Psychiatric Services*, August 2010, (61) 830.