Connecting the Dots - HIE Tools for Behavioral Health AGENDA

September 21st, 9:30-3 PM

Zoom Link with Registration: HITCommonsBHC2020

Topic	Presenter	Time
Welcome	Jessi Wilson OHA Shelley Buettner HIT Commons	9:30-9:40 AM
State of Onboarding	Liz Whitworth HIT Commons	9:45-10:15 AM
OHA Confidentiality Tool Kit for Providers	Kristin Bork OHA	10:15-10:35 AM
Updates to 42 CFR Part 2: Implications for Data Sharing	Michael Williams Vatsala Pathy Collective Medical	10:35-11:20AM
Break		11:20-11:30 AM
Interactive Q&A with Compliance Expert	Lynne Shoemaker Willamette Consulting Group, LLC	11:30-12 PM
Working Lunch Telehealth Discussion	Amy Fellows Fellows Connect, LLC Amber Clegg Deschutes County Behavioral Health	12- 12:45 PM
Transition to 1st Breakout		12:45-1 PM
Session A: Using the Collective Platform for Behavioral Health Care Coordination	Ian Bruce Collective Medical Jessica Turner Cascadia Behavioral Healthcare	1-1:45 PM
Session B: Prescription Drug Monitoring Program (PDMP) use in Behavioral Health prescribing	Mark Hetz HIT Commons Lara Irvin Appriss	1-1:45 PM
Transition to 2nd Breakout		1:45-2 PM
Session C: What's coming: Community Information Exchange (CIE)	Liz Whitworth HIT Commons	2-2:45 PM
Session D: Health Information Exchange (HIE) and opportunities for Behavioral Health	Paula Weldon Erick Maddox Reliance eHealth Collaborative	2-2:45 PM
Closing	Shelley Buettner HIT Commons	2:45-3 PM

How did we do? Event Feedback

Meet the Speakers

Welcome Session

Jessi Wilson, RHIA, MAT, Meaningful Use Programs Manager at the Oregon Health Authority's Office of Health IT is responsible for overseeing the Medicaid Electronic Health Records (EHR) Incentive Program (aka Medicaid Promoting Interoperability Program), and is also the office lead for the CCO 2.0 Health IT Roadmaps and Behavioral Health Health IT Workgroup. Previously, Jessi served in roles as the Medicaid EHR Incentive Program Auditor and an Operations & Policy Analyst for CareAccord. Prior to coming to the Oregon Health Authority, Jessi worked as a high school language arts teacher and varsity softball coach. Jessi holds a master's degree in teaching, and bachelor's degrees in health information administration and English literature from Pacific University. In her spare time, Jessi enjoys having adventures with her three young daughters and golfing with her husband.

Shelley Buettner, Consultant at HIT Commons is a 20+ year veteran of healthcare and healthcare IT, as a nurse, nurse practitioner, clinicalinformaticist, and leader of change at academic medical centers, multi-regional health systems, local nonprofits and healthcare technology companies. She has been involved in primary care transformation, assisted health systems through EHR implementations, built and expanded innovative health IT products, facilitated statewide IT solution implementations, and led primary care redesign work. Shelley received her BSN from the University of Nebraska, and her MSN from OHSU, is a Lean Green Belt, and is a Certified Professional in Healthcare Quality (CPHQ).

State of Onboarding/Session C: What's coming: Community Information Exchange (CIE)

Liz Whitworth, Managing Director for the Oregon Health Leadership Council (OHLC) and HIT Commons is engaged in the adoption and spread of several statewide initiatives involving health information technology, including the EDIE Utility/Collective Platform, the Prescription Drug Monitoring Program integration initiative and emerging work on a statewide Provider Directory and Community Information Exchange. Prior to OHLC and HIT Commons, Liz directed the Collective platform implementation at CareOregon and with its network partners. Liz has over 20 years of health care experience and holds a master's degree in public health.

OHA Confidentiality Toolkit

Kristin Bork, lead policy analyst at the Oregon Health Authority, manages the Health Information Exchange Onboarding Program (HIE Onboarding Program) in the Office of Health Information Technology. She has previously managed the Oregon Meaningful Use Technical Assistance Program and grants for five telehealth pilots.

Before joining OHA, Kristin was a United States Foreign Service Officer working on health development programs throughout the world, including Afghanistan and Vietnam.

Interactive Q&A with Compliance

Lynne Shoemaker, RHIA, CHP, CHC is a Consultant and owner of Willamette Consulting Group, LLC in Portland, Oregon. Lynne is Certified in Healthcare Compliance (CHC,) she is a Registered Health Information Administrator (RHIA,) and she is certified in Healthcare Privacy (CHP.) Lynne has a bachelor's degree from Western Oregon State, and a post-bachelor's certificate in Health Information Administration from Seattle University. She has over 30 years of experience in healthcare compliance. Lynne has expertise in developing and implementing compliance and ethics programs; compliance training programs; Codes of Conduct; compliance and HIPAA Privacy and Security policies and procedures; risk assessment checklists; and developing other compliance tools. Specialties: State and Federal healthcare legal compliance expertise regarding protected health information (PHI) and the privacy and security of e-PHI under the HIPAA regulations; 42 CFR Part 2 (Addiction Medicine); Health Information Exchange (HIE;) Risk assessment and risk mitigation execution expertise; expertise with Federal contractor and Grant compliance requirements; disaster recovery planning; process improvement; and Medicare and Medicaid compliance.

Updates to 42 CFR Part 2: Implications for Data Sharing

Michael Williams, General Counsel, Collective Medical is a corporate attorney whose practice areas include complex commercial transactions, technology licensing, SaaS agreements, health care compliance, information privacy, corporate finance, corporate governance, and employment matters. Michael is currently General Counsel and Chief Privacy Officer at Collective Medical where he has established common network governance principles and universal, reciprocal data use rights across the Collective Network — the nation's largest real-time care coordination network. Prior to working at Collective Medical, Michael worked in private practice, as inside counsel at a leading health data registry software provider, and in the federal government. Michael received his juris doctor degree from The George Washington University Law School and is a member of the Utah State Bar.

Updates to 42 CFR Part 2: Implications for Data Sharing

Vatsala Kapur Pathy, VP, Government Affairs, Collective Medical brings over two decades of experience in health policy and public health. She is the Founder and Managing Director of Rootstock Solutions LLC, a healthcare consulting firm and has federal and state clients including the Office of the National Coordinator for Health Information Technology at the U.S. Department of Health and Human Services. Previously, she was a Senior Advisor to the Centers for Medicare and Medicaid Innovation at the Centers for Medicare and Medicaid Services. She also served as the Colorado State Innovation Model Director in the Office of Governor John Hickenlooper, a statewide delivery system and payment reform initiative focused on the integration of behavioral health and primary care. Vatsala served as a senior program officer at The Colorado Health Foundation, where she was responsible for grant making and initiative development to support healthcare delivery for low-income populations and as a program officer at the CDC Foundation, where she served as a steward and manager of a number of national and international public health projects. She has extensive experience on state health policy research and program implementation with the Office of Colorado Governor Roy Romer, the Georgia Health Policy Center and Kaiser Foundation Health Plan of Colorado. Vatsala is a recipient of The Livesay Award for Social Change from The Colorado College and The American Marshall Memorial Fellowship. She was also selected to participate in the University of Colorado's Denver Community Leadership Forum. She is presently a Chair at World Denver and a board member of the Children's Museum of Denver, the Bell Policy Center and the New Venture Fund. Previously, she has also served as an Operating Board member of Bonfils Blood Center and a Trustee at St. Anne's Episcopal School. Vatsala received a Master of Public Affairs from the Lyndon B. Johnson School of Public Affairs, and a Master of Arts degree from the Institute of Latin American Studies at the University of Texas at Austin. She graduated cum laude with distinction with a Bachelor of Arts degree in political science and history with a Latin America concentration and a minor in North American Studies from The Colorado College. She has a Certificate in Mediation from the University of Denver.

Working Lunch Telehealth Discussion

Amy Fellows, MPH is an experienced healthcare and healthcare information technology (HIT) professional with over 20 years experience. Amy worked at OCHIN,Inc for 10 years in the capacity of Project Manager for both Practice Management and Electronic Health Record installations at safety net clinics, Federally Qualified Health Centers, School Based Health Centers and Public Health Departments in multiple states. Amy has done Health IT projects in a consulting role with In June 2010, Amy started her own consulting business, Fellows Health Connect, LLC. In this capacity she has worked on the State of Oregon's Health Information Exchange project, Medicaid Health Incentive project, and assisted the Coalition of Community Clinics, Project Access NOW, the Oregon Health Care Quality Corporation (Q-Corp) and was hired by Kaiser Permanente's community fund to provide Technical Assistance for Behavioral Health/Primary Care Integration projects (worked with Oregon Primary Care clinics on incorporating the SBIRT questions into their EHR workflows). Amy was the co-chair of the Northwest OpenNotes Consortium that brought the OpenNotes concept to Oregon and was the Vulnerable Populations expert with the national OpenNotes team at Beth Israel Deaconess Medical Center in Boston, MA. Today Amy continues to do HIT consulting primarily with safety net clinics independently and with Pivot Point Consulting.

Working Lunch Telehealth Discussion

Amber Clegg, LPC, CADC III, Deschutes County Health Services has a Master's Degree in Counseling Psychology from Pacific University. She has been a behavioral health clinician for over 20 years and a clinical supervisor for over 12 of those years. Her areas of focus have primarily been with forensic diversion programs, such as, mental health and drug court programs and intake/assessment processes. Amber also worked extensively on two major EHR implementations and has been a project lead for several agency wide initiatives, such as, becoming a CCBHC clinic. In addition, she has her Civil Commitment Investigator and CANS certifications and is a qualified DLA 20 trainer. She is currently the Access Team Supervisor and a project manager for piloting the Rapid Engagement Model at Deschutes County Health Services.

Session A: Using the Collective Platform for Behavioral Health Care Coordination

Ian Bruce, LPC, Clinical Solutions Lead for Collective Medical, vendor for the Collective Platform (i.e. EDie, PreManage) works to support care team members and organizations in collaborating & coordinating across systems to improve patient care. Ian advocates and focuses primarily within Mental Health and SUD use cases, as well as Workplace Safety & overall Transitions of Care. Prior to joining the Collective team, Ian worked in the Emergency Departments at both Providence Portland Medical Center & Providence St Vincent Medical Center where he was an end-user of Collective as an ED CIS performing psychiatric assessments, followed by beginning at Providence Portland an intensive case management and care coordination program focused on assertive outreach and engagement while using Collective to provide wraparound supports to patients with complex behavioral health needs and high ED/IP utilization.

Jessica Turner, LPC, CADCIII, Director of Clinical Systems at Cascadia Behavioral Health has a Masters of Counseling from Lewis and Clark College-followed by CADCIII. She has held several positions at Cascadia over the years: Clubhouse Advocate, Case Manager, Clinical Supervisor, Program Manager, Dual Diagnosis Specialist, Manager of Addictions, Director of Dual Diagnosis, EHR Specialist, Director of Clinical Systems. Jessica started consulting to make sure our mental health heavy company wouldn't forget SUD when rolling out the EHR and ended up directing 3 EHRs along with other clinical systems like Collective Medical's Premanage.

Session B: Prescription Drug Monitoring Program (PDMP) use in Behavioral Health prescribing

Mark Hetz, Executive Director of HIT Commons has over 35 years of experience in health information technology leadership. Previously Mark was the Senior Vice President/Chief Information Office at Asante Health System for 24 years. In addition to information technology, Mark had various responsibilities for numerous other support services functions and oversaw numerous large construction projects. In addition to his service as Executive Director of HIT Commons, Mark serves in the following capacities: Board Member of Apprise Health Insights, the for-profit subsidiary of the Oregon Association of Hospitals and Health Systems providing data analytics service, Member of Health Information Technology Oversight Council of the Oregon Health Authority, Senior Research Director with Advisory Board.

Lara Irvin, Manager of Client Relations for Appriss brings 20 of years of experience in client relations, training, implementation and sales to her role at Appriss Health as Manager of Client Relations. Lara oversees the support and strategic initiatives of 22 of the 43 prescription drug monitoring programs (PDMP) managed by Appriss Health. Lara leads a team of client relationship managers in partnering with state administrators stakeholders to create and execute solutions, such as integrating PDMP data within clinical workflow to strengthen and streamline access to the state PDMP data. Lara is passionate about being part of a team combating the opioid crisis through the Appriss mission of utilizing data driven solutions to provide knowledge for good. Before joining Appriss Lara was the Director of Implementation and Training for recruiting and onboarding technology company. Lara championed migration and implementation of their SAAS based recruiting and onboarding platform, as well as created training materials and leading end user and administrator training.

Session D: What's coming: Community Information Exchange (CIE)

Paula Weldon has over 25 years' experience in health information technology related activities with both health systems and health plans for physical, dental, and behavioral health workflows. She currently oversees operations for Reliance eHealth Collaborative, Health Information Exchange (HIE) which includes the implementation staff, communication and outreach strategies, technical interfaces, and data analytic project teams. Paula has a Bachelor of Science degree in Innovation and Leadership. She currently participates on the Oregon Prescription Drug Monitoring Program (PDMP) Integration Steering Committee.

Erick Maddox, Executive Director for Reliance eHealth Collaborative began is career working in residential treatment with at risk children in the foster care system with issues related to abuse, abandonment, neglect, and drug and alcohol abuse. After participating in an organizations EHR adoption efforts Erick migrated into the health information technology field and in 2010 joined the Regional Extension Center efforts in Utah and Nevada to help lead efforts in EHR adoption and meaningful use achievement in the region. At the same time Erick also signed on to support the work to establish Nevada's Community Based Health Information Exchange eventually leading the Statewide HIE Adoption effort. After spending the majority of his life in the desert southwest Erick took the opportunity to relocate to Oregon at the beginning of 2017 to assume the role of Executive Director for Reliance eHealth Collaborative where he is happy to have the opportunity to grow the HIEs footprint and capabilities.

Connecting the Dots:
HIE Tools for Behavioral Health

September 21, 2020

IN PARTNERSHIP WITH

OREGON HEALTH LEADERSHIP COUNCIL | Oregon Health Authority

Background – Why We are Here

- Behavioral Health HIT Workgroup recommendations:
  - Information sharing guidance/support related to privacy & security
  - Provide Health Information Technology (HIT)/Health Information Exchange (HIE) education
  - Create shared learning opportunities

- HIT Commons
  - Public/private governance model co-sponsored by OHLC & OHA
  - Advances HIE adoption and use across the state
  - Oversees 2 core programs:
    - EDIE/PreManage and PDMP Integration
  - Additional initiatives:
    - Oregon Provider Directory and Oregon Community Information Exchange

Goals of Today's Event

- Receive information on available HIE tools and resources for behavioral health providers
- Engage in discussions with subject matter experts and peers related to HIE, telehealth, and confidentiality issues, particularly around substance use disorder (SUD) patient records
- Learn something new/make new connections to help you navigate the HIE challenges in the behavioral health setting

Oregon Health Authority

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Learning Collaborative Audience

- 101 registrants
  - 55 organizations
  - Role/department
    - 28% Management/ Administration
    - 27% Not specified
    - 20% Other
    - 16% IT
    - 5% Provider
    - 4% Compliance/Risk

Oregon Health Authority

Behavioral Health State of Onboarding with HIE/HIT Tools
September 21, 2020 BH Community Collaborative

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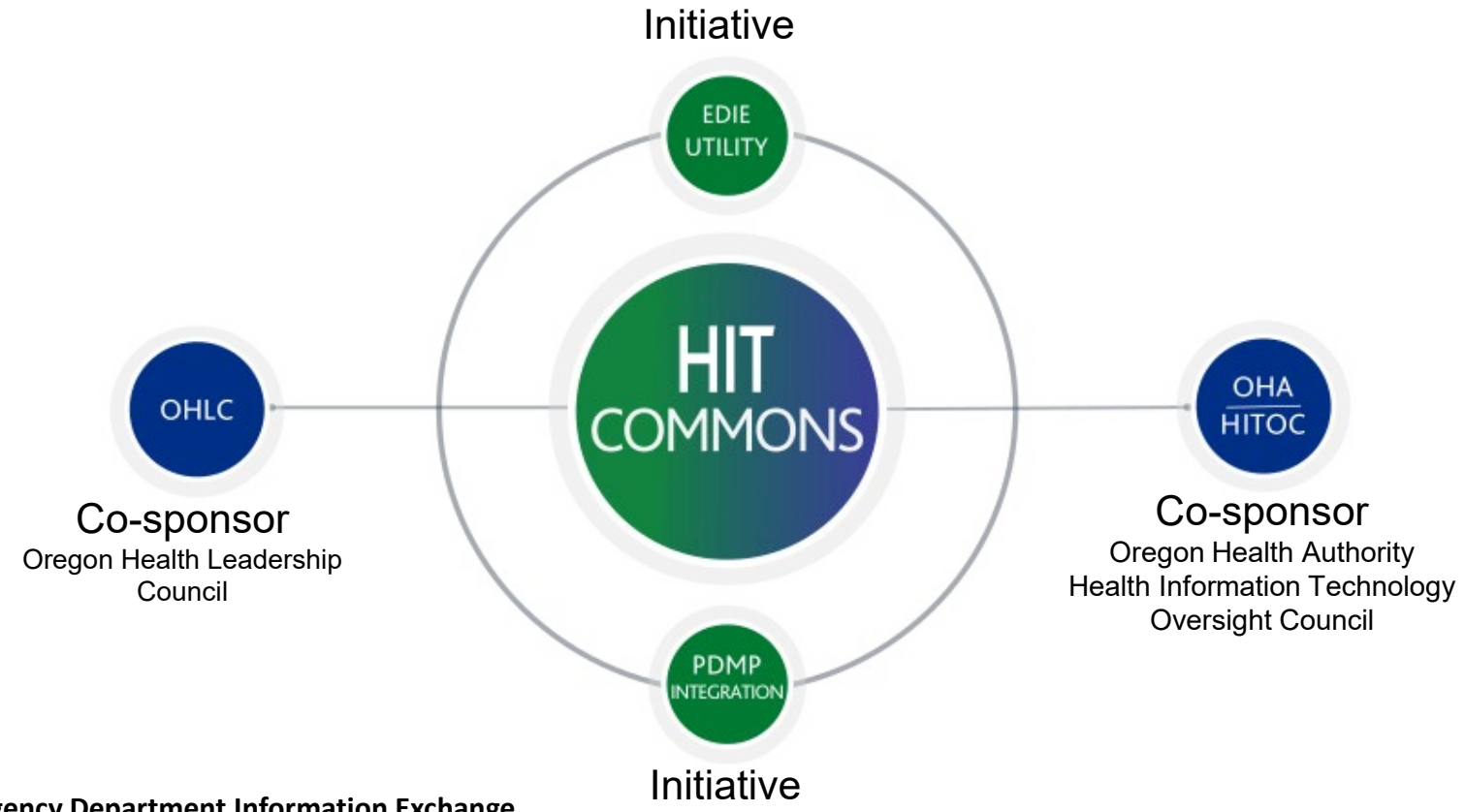
HIT Commons

A shared public/private governance partnership to accelerate and advance health information technology in Oregon



Co-sponsor
Oregon Health Leadership Council

Co-sponsor
Oregon Health Authority Health Information Technology Oversight Council

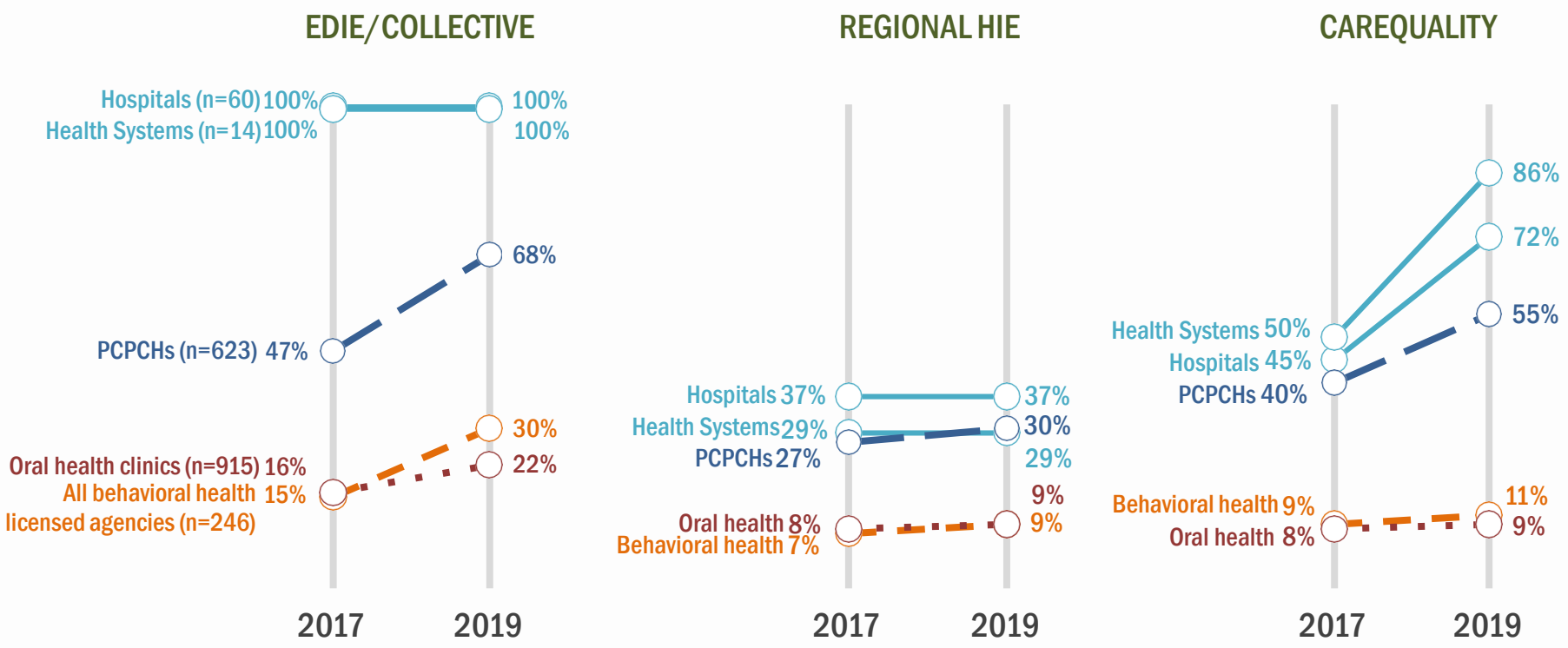
EDIE: Emergency Department Information Exchange
PDMP: Prescription Drug Monitoring Program

HIT Commons Overview

- A public/private partnership to govern high priority, statewide HIT Initiatives with OHA as public sponsor.
- Mission: to accelerate and advance Health Information Technology adoption and use across the state.
- Build off Oregon's history of successful collaboration such as EDie/PreManage.
- Intended to help connect existing HIT systems, support statewide solutions.
- OHA is voting member of Board and provides significant funding via state and federal funding opportunities.

Today’s HIE/HIT landscape

Adoption of various HIE/HIT tools in Oregon

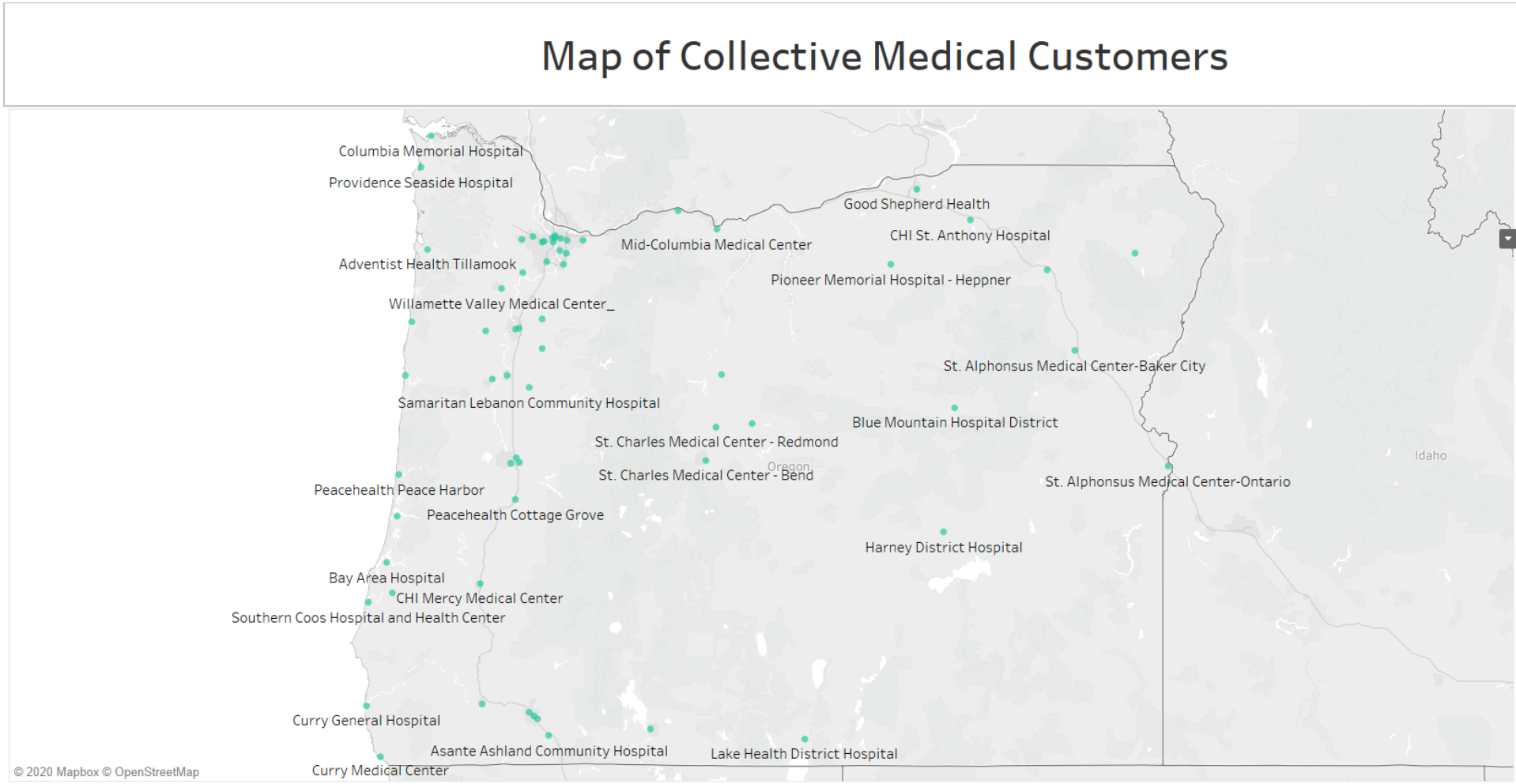


Oregon Health Authority - Office of Health InformationTechnology

Oregon Health Authority

63 Oregon Hospitals Connected to EDIE/Collective

Note: Not all hospital names show on map in this format



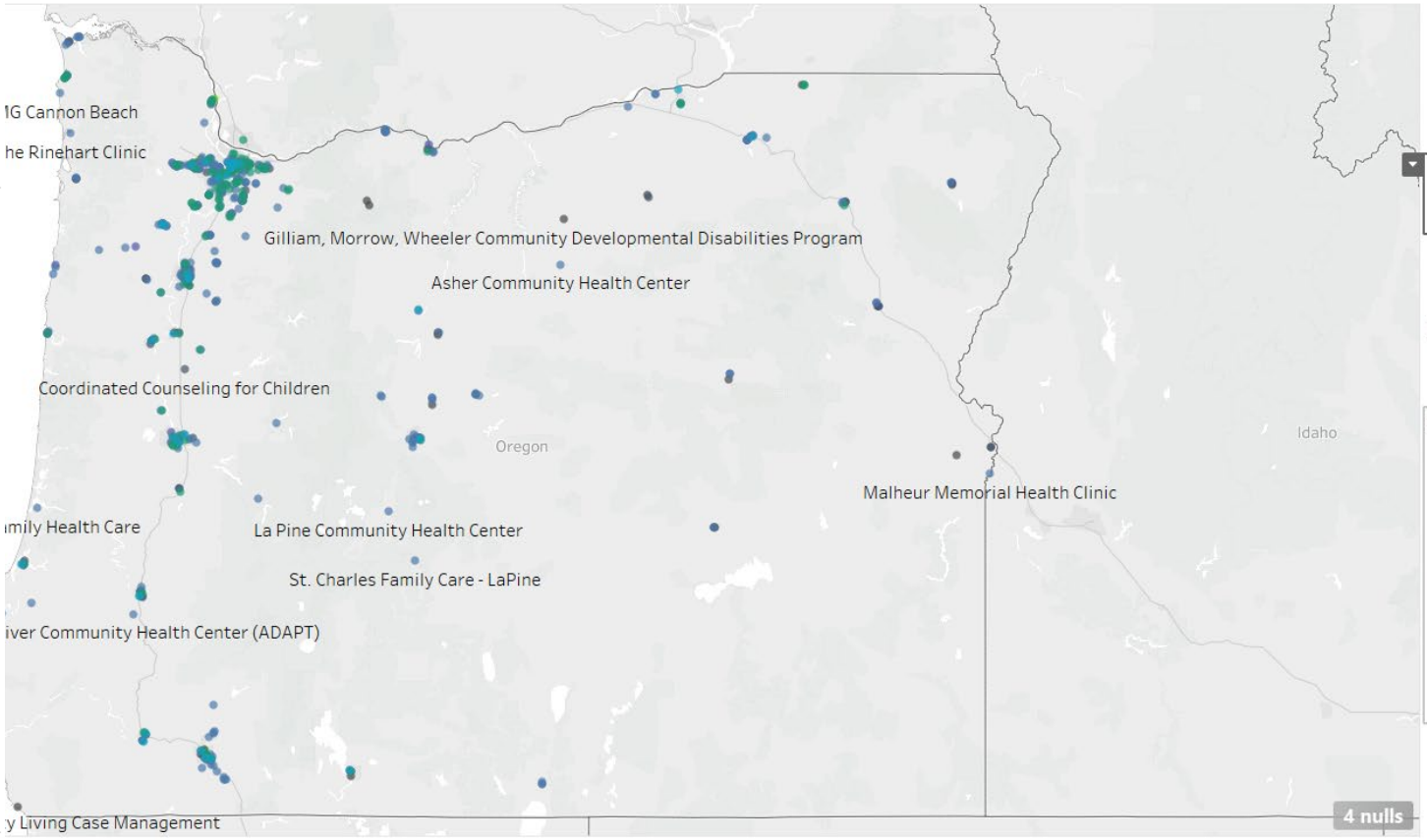
Nearly 1,000 Ambulatory and Post Acute Facilities Connected

Facility Type
- Payers/Risk Bearing
- Social Services Agency
- EMS
- Other
- Behavioral Health
- Post Acute
- Hospitals
- PC Clinics

Total Facilities

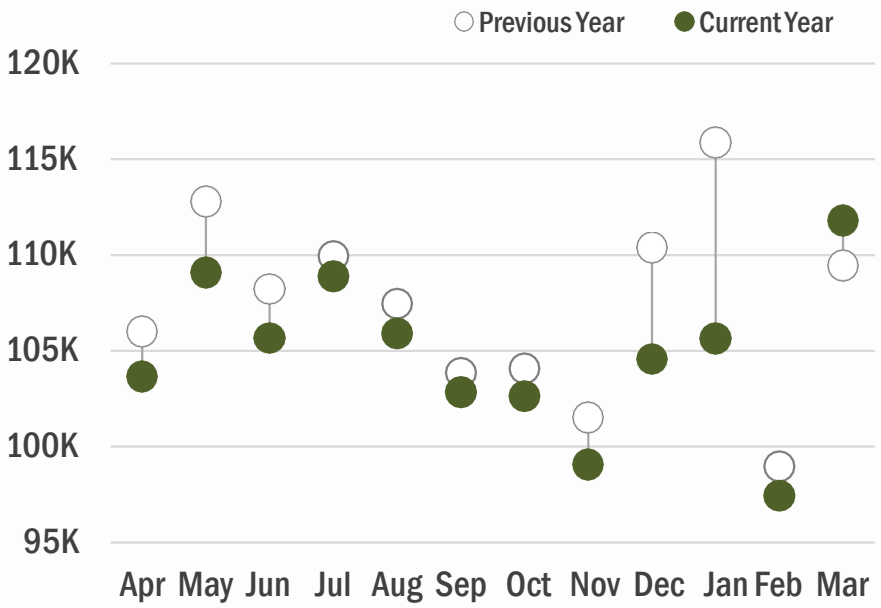
Payers/Risk Bearing	34
Post Acute	109
Behavioral Health	59
EMS	2
PC Clinics	358
Other	69
Hospitals	63
Social Services Agency	35

Map of Collective Medical Customers

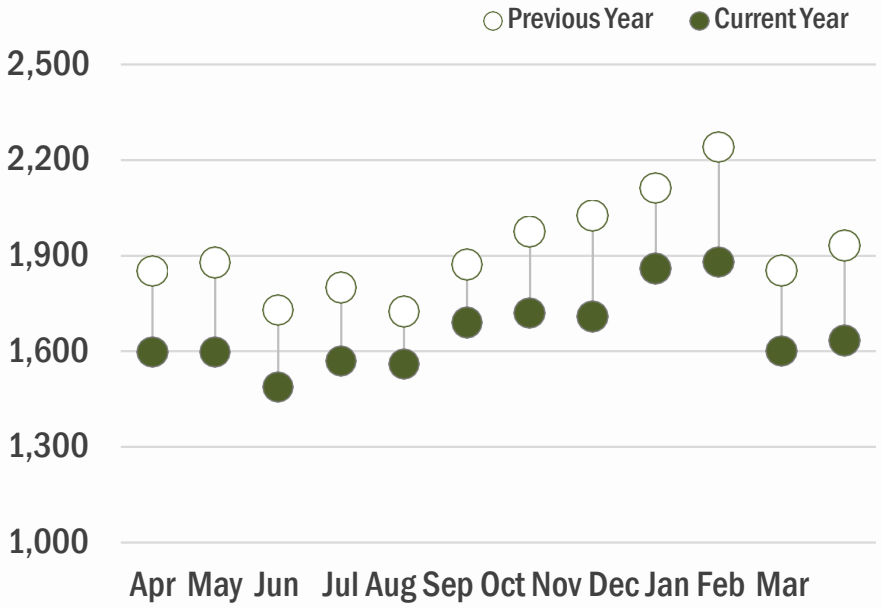


Emergency Department visits are decreasing

The number of total ED visits decreased by 2.5% from 2018 to 2019.



Potentially avoidable visits from High Utilizers decreased by 13.5% from 2018 to 2019.



But more recent data show increases in behavioral health visits…

Q1 2019 - Q4 2019 EDIE DASHBOARD

HIGH UTILIZER COMORBIDITY & MENTAL HEALTH BY REGION

Insights:

- Southern Coast and Northwest Oregon were the only regions to see decreases in visits.

-The largest increases came from Central Oregon (63.5%) and Southern Oregon (13.7%).

-Major depressive disorder was a top diagnosis in all regions.

-Central Oregon was the only region to have nausea with vomiting and headache among its top five diagnoses

Please see the appendix page for region definitions

Portland Metropolitan Area

Previous Year	7,694
Current Year	8,521

Top Diagnoses, FY 2019

Major depressive disorder, single episode, unspecified	567
Suicidal ideations	400
Schizophrenia, unspecified	228
Unsp psychosis not due to a substance or known physiol cond	224
Anxiety disorder, unspecified	222

Central Oregon

Previous Year	1,993
Current Year	3,259

Top Diagnoses, FY 2019

Chest pain, unspecified	135
Unspecified abdominal pain	121
Headache	67
Major depressive disorder, single episode, unspecified	62
Nausea with vomiting, unspecified	59

Eastern Oregon

Previous Year	939
Current Year	1,040

Top Diagnoses, FY 2019

Anxiety disorder, unspecified	49
Unspecified abdominal pain	35
Major depressive disorder, single episode, unspecified	26
Other chest pain	26
Chest pain, unspecified	22

Southern Coast

Previous Year	274
Current Year	201

Top Diagnoses, FY 2019

Major depressive disorder, single episode, unspecified	48
Schizophrenia, unspecified	22
Anxiety disorder, unspecified	12
Suicidal ideations	7
Dizziness and giddiness	5

Valley

Previous Year	2,616
Current Year	2,842

Top Diagnoses, FY 2019

Major depressive disorder, single episode, unspecified	248
Suicidal ideations	118
Schizophrenia, unspecified	113
Anxiety disorder, unspecified	88
Bipolar disorder, unspecified	82

Southern Oregon

Previous Year	2,590
Current Year	2,946

Top Diagnoses, FY 2019

Major depressive disorder, single episode, unspecified	99
Chest pain, unspecified	86
Anxiety disorder, unspecified	85
Suicidal ideations	63
Urinary tract infection, site not specified	56

Northwest Oregon

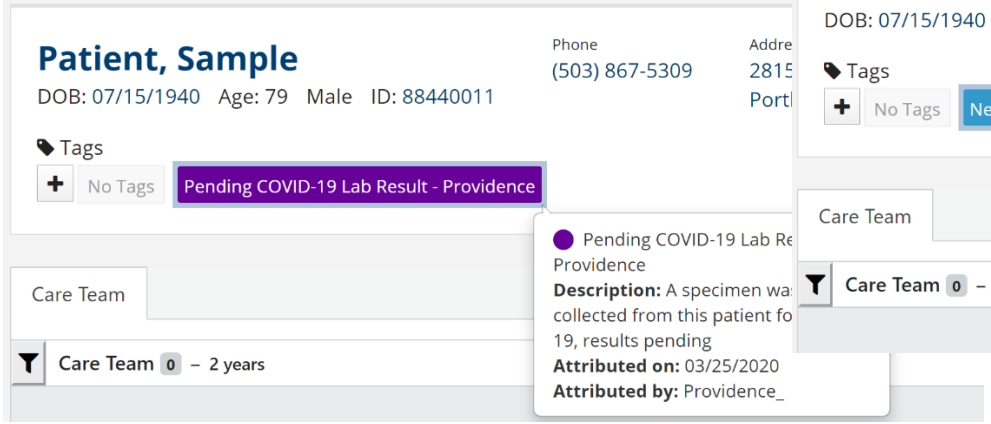
Previous Year	373
Current Year	331

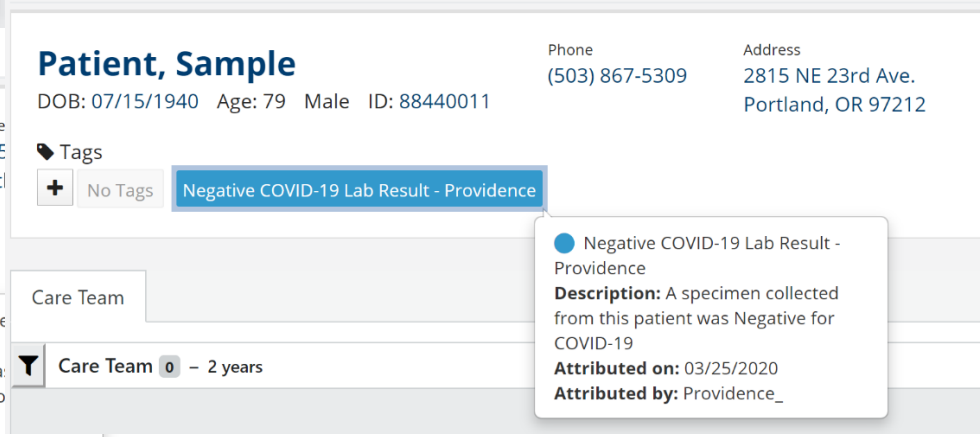
Top Diagnoses, FY 2019

Major depressive disorder, single episode, unspecified	44
Suicidal ideations	42
Anxiety disorder, unspecified	18
Schizophrenia, unspecified	18
Bipolar disorder, unspecified	12

apprise HEALTH INSIGHTS

Collective and Reliance Tools: Assisting with COVID-19 Response





- Some hospitals sharing COVID status data through existing ADT feeds
- Reliance HIE sending ORU interface feeds with lab results
- Orpheus statewide file feed under discussion for additional data flow

What's Coming for Behavioral Health

- Existing tools:
  - Continued opportunity for adoption and spread
  - Technical assistance and collaboratives—like today!
- New tools:
  - Within Collective Platform, new functionality for:
    - Behavioral Health Consent
    - MAT referrals
    - Other (e.g., possible overdose cohorts/notifications)
  - Community Information Exchange (CIE) to connect clinical and social service providers—more later today!

To learn more about Oregon's HIT/HIE developments, subscribe to our email list!

www.HealthIT.Oregon.gov

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HIT Commons

http://www.orhealthleadershipcouncil.org/hit-commons/

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Behavioral Health Confidentiality Tool Kit for Providers

Kristin Bork

September 2020

Oregon Health Authority

Agenda

- Brief review of background and purpose of the toolkit
- Overview of toolkit
- Changes to 42 CFR Part 2
- Questions

Background

- In 2015, OHA created an **internal Behavioral Health Information Sharing Advisory Group** to help improve coordination between physical health and behavioral health providers.
- One of the outcomes of the work of the Behavioral Health Information Sharing Advisory Group is the ***Confidentiality Toolkit for Providers***.
  - We have heard that many providers in the state would like **guidance about behavioral health information sharing and the intersection of state and federal law**, especially around information sharing of substance use, diagnoses and treatment.

The Toolkit Does

- Support integrated care
- Provide overview of confidentiality issues/perceived obstacles
- Provide links to additional information

The Toolkit Does not

- Offer legal advice
- Take place of legal counsel

Confidentiality Toolkit

The toolkit includes:

- Consent Sample Templates
- Chart of relevant statutes
- FAQs – which are being developed from past webinars and questions that OHA staff receives
- Use Cases, which will include examples of sharing of behavioral health information relevant to 42 CFR Part 2 protected information

Stakeholder Input onToolkit

- Toolkit will be helpful and should be user friendly
- Needs to provide clarifications on different types of info sharing agreements and examples
- Should be periodically updated to reflect changes in the environment, including regulations around sharing

42 CFR Part 2 Revision, Final Rule*

The 42 CFR part 2 regulations serve to protect patient records created by federally funded programs for the treatment of substance use disorder (SUD). SAMHSA released revisions to part 2 in Summer 2020, to facilitate better coordination of care for substance use disorders which will also enhance care for opioid use disorder (OUD). These provisions will be an important part of the Federal response to the opioid epidemic, while maintaining part 2 confidentiality protections.

*https://www.hhs.gov/about/news/2020/07/13/fact-sheet-samhsa-42-cfr-part-2-revised-rule.html

42 CFR Part 2 Revision, Final Rule*

Changing Under the New Part 2 Rule:

There are a number of modifications to sections of Part 2. You can find these changes at: https://www.hhs.gov/about/news/2020/07/13/fact-sheet-samhsa-42-cfr-part-2-revised-rule.html

One example of a change is:

An SUD patient may consent to disclosure of the patient's Part 2 treatment records to an entity (e.g., the Social Security Administration), without naming a specific person as the recipient for the disclosure.

42 CFR Part 2 Revision*

What's Not Changing Under the New Part 2 Rule:

- The revised rule does not alter the basic framework for confidentiality protection of substance use disorder (SUD) patient records created by federally assisted SUD treatment programs
- Part 2 continues to prohibit law enforcement's use of SUD patient records in criminal prosecutions against patients, absent a court order.
- Part 2 also continues to restrict the disclosure of SUD treatment records without patient consent, other than as statutorily authorized in the context of a bona fide medical emergency; or for the purpose of scientific research, audit, or program evaluation; or based on an appropriate court order.

*https://www.hhs.gov/about/news/2020/07/13/fact-sheet-samhsa-42-cfr-part-2-revised-rule.html

Updates to 42 CFR Part 2

Link to rule fact sheet is here:

https://www.hhs.gov/about/news/2020/07/13/fact-sheet-samhsa-42-cfr-part-2-revised-rule.html

Confidentiality Tool Kit for Providers

Here is the link for the tool kit:

https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le8271.pdf

Questions?

Oregon Health Authority

42 CFR Part 2 — Recent & Upcoming Changes

September 21, 2020

HIGHLY CONFIDENTIAL – DO NOT SHARE

Vatsala Pathy
VP, Regulatory & Government Affairs

Michael J. Williams, J.D.
General Counsel & Chief Privacy Officer

collectivemedical®

I. **Background & History**

II. SAMHSA's July 2020 Final Rule

III. Section 3221 of the CARES Act

42 CFR Part 2 History (1975, 1987, 2017)

- Developed to address concerns about the potential use of Substance Use Disorder (SUD) information in non-treatment-based settings such as administrative or criminal hearings related to the patient. Protects confidentiality of the identity, diagnosis, prognosis, or treatment of any patient records maintained in connection with the performance of any federally assisted program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation or research. Intended to ensure that a patient receiving treatment for a SUD in a Part 2 Program does not face adverse consequences in relation to issues such as criminal proceedings and domestic proceedings such as those related to child custody, divorce or employment.
- The 2017 final rule modernizes the Part 2 rules by facilitating the electronic exchange of substance use disorder information for treatment and other legitimate health care purposes while ensuring appropriate confidentiality protections for records that might identify an individual, directly or indirectly, as having a substance use disorder.
  - Permits use of electronic signatures.
  - Prohibition on re-disclosure only applies to information that would identify, directly or indirectly, an individual as having been diagnosed, treated, or referred for treatment for a substance use disorder, such as indicated through standard medical codes, descriptive language, or both, and allows other health-related information shared by the Part 2 program to be re-disclosed, if permissible under other applicable laws.
  - Clarifies that both Part 2 programs and other lawful holders of patient identifying information must have in place formal policies and procedures for the security of records, including sanitizing media associated with both paper and electronic records. Must reasonably protect against unauthorized uses and disclosures of patient identifying information and protect against reasonably anticipated threats or hazards to the security of patient identifying information.
  - Updates rules on sanitizing records.

Other Key Related Legislation & Environmental Trends

HIPAA

- Enacted in 1996 and generally permits the disclosure of protected health information for certain purposes without patient authorization, including treatment, payment, or health care operations.

MARCA

- Certified HIT for advanced APMs includes a focus on improving care coordination.
- Certified EHR technologies may support the interoperable exchange of critical health information so that providers can deliver informed, effective care regardless of setting.
- Focus on value-based purchasing which is core value proposition for our products.

21st Century Cures Act

- Calls for new spending of $1 billion in grants to states to support efforts to prevent and treat the consequences of opioid misuse and abuse. The grants are tied to states and the mechanisms used to distribute substance abuse prevention and treatment block grant funds.
- Section 4004: Identifying reasonable and necessary activities that do not constitute information blocking
- Push toward interoperability through other sections of 21st Century Cures.

Issues

Hot Button Issues

- Discrimination
- Loss of privacy
- Growing prevalence of cyber attacks/data breaches
- Stigma
- Fears related to delaying or not receiving treatment
- Push and pull between interoperability and privacy

Issues Driving Policy Discussion

- Growth of integrated care
- Growth of electronic information exchange
    - Consent management
    - Redisclosure
- Performance/quality measurement

Revised Rule (2020)

- Part of the Deputy Secretary's Regulatory Sprint to Coordinated Care.
    - “The lack of critical substance use history in a patient's medical record can lead to potentially damaging consequences for a person with a substance use disorder and can further stigmatize these conditions," said Assistant Secretary Elinore F. McCance-Katz. "This rule aims to ease the sharing of information, reduce burden for providers, and increase access to care for individuals while at the same time maintaining important privacy controls.”
- Will not alter the basic framework for confidentiality protection of SUD patient records created by federally funded treatment programs.
- Part 2 will also continue to restrict the disclosure of SUD treatment records without patient consent, other than as statutorily authorized in the context of a bona fide medical emergency; or for the purpose of scientific research, audit, or program evaluation; or based on an appropriate court order for good cause.

I. Background & History

II. SAMHSA's July 2020 Final Rule

III. Section 3221 of the CARES Act

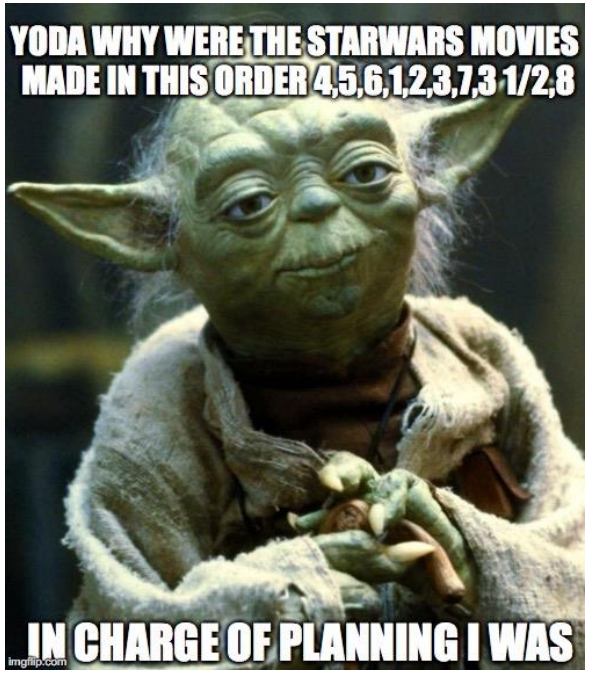
The usual disclaimer …

Although I am an attorney, I am not *your* attorney.

The information in this presentation does not constitute legal advice.

The timeline is admittedly confusing.

	SAMHSA	Congress
August 26, 2019	Notice of Proposed Rulemaking (NPRM) (84 FR 44568)	
March 27, 2020		CARES Act signed into law (Pub. L. 116-136)
July 15, 2020	Publication of Final Rule (85 FR 42986)	
August 14, 2020	The July 15, 2020 Final Rule becomes effective.	
[Before March 27, 2021]	Notice of *more* proposed rules to implement § 3221 of the	
[By March 27, 2021]	Rules implementing § 3221 of the CARES Act become effective.	



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This Final Rule does **not** implement § 3221 of the CARES Act.

More rulemaking is in the works to implement § 3221 of the CARES Act.

July 2020 Final Rule

Clarification re Applicability

Treatment records about SUD created by non-Part 2 providers based on their own patient encounter(s) are not covered by Part 2.

Exception: SUD records received from a Part 2 program are incorporated into such records.

Non-Part 2 provider is to segment external Part 2 records so the patient's general records don't become subject to Part 2.

§§ 2.11, 2.12, 2.32

Clarification re Device "Sanitizing"

When an SUD patient sends an incidental message to the personal device of an employee of a Part 2 program, the employee will be able to fulfill the Part 2 requirement for "sanitizing" the device by deleting that message.

§§ 2.16, 2.19

Removal of Requirement to Name Individual Recipient

SUD patients may consent to disclosure of Part 2 treatment records to a **third-party non-treating entity** (e.g., the Social Security Administration) without naming a specific person as the recipient for the disclosure.

The amended section inserts the words "or the name(s) of the entity(-ies)" in the operative provision.

§ 2.31

July 2020 Final Rule

Clarification re Payment & Health Care Operations

Disclosures for the purpose of *most* "payment and health care operations" are permitted with written consent.*

*The consent still needs to name the specific recipient entity.

§ 2.33 (previously just in the preamble)

Disclosures to PDMPs

Non-OTP (opioid treatment program) providers will become eligible to query a central registry, in order to determine whether their patients are already receiving opioid treatment through a member program. OTPs will be permitted to enroll in a state prescription drug monitoring program (PDMP), and permitted to report data into the PDMP when prescribing or dispensing medications on Schedules II to V, consistent with applicable state law.

§§ 2.34, 2.36 (new)

Declared Emergencies

Declared emergencies resulting from natural disasters (e.g., hurricanes) that disrupt treatment facilities and services will meet the definition for a "bona fide medical emergency," for the purpose of disclosing SUD records without patient consent under Part 2.

§ 2.51

July 2020 Final Rule

Research

Disclosures for research under Part 2 are permitted by a HIPAA-covered entity or business associate to individuals and organizations who are neither HIPAA covered entities, nor subject to the Common Rule (re: Research on Human Subjects).

§ 2.52

Clarification re Audit & Evaluation

Clarifies specific situations that fall within the scope of permissible disclosures for audits and/or program evaluation purposes (e.g., to improve care, review appropriateness of care, etc.).

Patient-identifying information may be disclosed to federal, state, or local government agencies, and to their contractors, for audits or evaluations required by law.

§ 2.53

Undercover Agents & Informants

Court-ordered placement of an undercover agent or informant within a Part 2 program is extended to a period of 12 months, and courts are authorized to further extend the period of placement through a new court order.

§ 2.67

Meanwhile …

I. Background & History

II. SAMHSA's July 2020 Final Rule

III. <u>Section 3221 of the CARES Act</u>

§ 3221 of the CARES Act

“Real” changes to 42 CFR Part 2 …

- have been a long time coming and
- required changes to the underlying legislation. I.e., a literal act of Congress.

Those changes were included in a much-less-talked-about subsection of the Coronavirus Aid, Relief and Economic Security Act (“CARES Act”) (Pub. L. 116-136), signed into law on March 27, 2020.

§ 3221 of the CARES Act

Three Major Objectives:

1. Reduce Stigma
2. Improve Patient Outcomes
3. Improve Certain Safeguards

§ 3221 of the CARES Act

§ 3221 of the CARES Act makes significant changes to the underlying statutes that govern the confidentiality of SUD information, specifically at **42 U.S.C. §290dd-2**.

Those statutory changes call for HHS (via SAMHSA) to update / create regulations to implement these new changes, which will be updated at **42 CFR Part 2**.

The specific changes to Part 2 will not take effect (or even be fully known) until SAMHSA completes in rulemaking.

BUT … we can still glean a lot from the CARES Act in anticipation of the rules to come.

§ 3221 of the CARES Act

1. Expansion of permitted uses and disclosures of SUD information under Part 2 so that they more closely align with those of the HIPAA Privacy Rule (while still requiring the patient's consent).

2. Elimination of the non-redisclosure requirement (beyond the partial elimination already implemented under the July 2020 Final Rule).

3. Breach notification requirements that align with those under HIPAA around PHI.

4. Updated enforcement and penalty structures that align with those under HIPAA around PHI.

5. Prohibition of using SUD information to discriminate against individuals, including with regards to access to treatment for health care, hiring or firing decisions, sale, rental, or continued rental of housing and access to government services and benefits.

6. Limitations on use and disclosure of SUD information against SUD patients in judicial or administrative proceedings.

§ 3221 of the CARES Act

Expansion of permitted uses and disclosures of SUD information under Part 2 so that they more closely align with those of the HIPAA Privacy Rule (while still requiring the patient's consent).

- Patient's consent is still required.
- Eliminates the patient's legal inability to provide a consent that is sufficiently broad to enable ***any*** party that has a Treatment, Payment, or Health Care Operations (TPO) relationship with the patient to access/use/disclose the patient's SUD information for full TPO purposes.
- HIPAA Covered Entities with a TPO relationship with the patient may use and disclose that SUD information under their regular permitted purposes paradigm (or something very close to it), provided that the patient has provided consent and has not revoked that consent.

§ 3221 of the CARES Act

Elimination of the non-redisclosure requirement.

- § 3221 amends 42 U.S.C. 290dd–2(b) to include the following provision: “It shall be permissible for a patient’s prior written consent to be given once for all such future uses or disclosures for purposes of treatment, payment, and health care operations, until such time as the patient revokes such consent in writing.” CARES Act § 3221 (b).
- SUD information disclosed by Part 2 Programs will no longer need to be accompanied by a non-redisclosure notice.
- That SUD information will be able to be treated by Covered Entities under the same TPO framework with which they treat PHI generally, provided that the patient has provided consent and has not revoked that consent.

§ 3221 of the CARES Act

Breach Notifications.

- Currently, Part 2 imposes no requirement to self-report a breach of covered SUD information.
- The CARES Act introduces the concept of a "breach" and ties it both to the definition and to the notification requirements that are applied by the HIPAA regulations with respect to PHI.
- Recall that, subject to exceptions, a "breach" under HIPAA is the use or disclosure of information where such use or disclosure is impermissible under the Privacy Rule and that compromises the security or privacy of the information.
- Some of the details will need to be addressed in rulemaking, but it would appear that, given that Part 2's consent obligations don't apply to PHI generally, there will likely be events that rise to the level of a reportable breach with respect to SUD information, but which nevertheless are not reportable breaches with respect to any non-SUD PHI implicated in such events.

§ 3221 of the CARES Act

Enforcement and Penalties.

- Historically, Part 2 violations carried criminal fines under Title 18.
- The CARES Act replaces the existing penalties provisions of 42 U.S.C. 290dd–2 that impose criminal fines under Title 18 and instead **aligns enforcement and penalties with those that apply to HIPAA** regarding PHI.
- While this move away from criminal penalties may appear to provide some relief to those concerned with compliance, the civil and monetary penalties under HIPAA are often still very significant.
- Moreover, because responsibility for enforcing Part 2 is moving away from Federal prosecutors and to the desk of OCR, we are almost certainly going to see **a much more active enforcement regimen**.
    - Recall that when criminal prosecution was the only available enforcement mechanism for Part 2, the result was virtually zero enforcement.

§ 3221 of the CARES Act

Details to Come in the Regs.

The CARES Act leaves many details to be nailed down in the regs. For example, the CARES Act does not identify the specific elements that will be required in a valid Part 2 consent going forward. We expect significant changes to 42 CFR § 2.31 in that area. Given the attempt of the CARES Act to align Part 2 with HIPAA around the permitted purposes for use and disclosure of information, it's not an unreasonable **assumption** that SAMHSA's rulemaking process will result in updates to the required consent elements in ways that are consistent with the required consent elements under HIPAA.

U.S.Department of Heath and Human Services

SAMHSA
Substance Abuse and Mental Health Services Administration

THANK YOU

collectivemedical®

Interactive Q&A With a Compliance Expert

Lynne Shoemaker, RHIA, CHP, CHC

Please Remember

- Information presented here is my opinion based on my years of experience in both large and small organizations
- I am not a lawyer
- I am not your Compliance Officer
- Please consult with your legal counsel and your Compliance Officer

Questions to Think About

How do you know if 42 CFR Part 2 applies to your patients?

- Does your organization have both medical and addiction medicine treatment programs?
  - Information sharing?
- Are you a provider who provides addiction medicine treatment or medical treatment?
  - Both?
- Do you work in a special unit within a hospital or clinic that advertises that the unit provides addiction medicine treatment?

Questions to Think About continued…

- What will you do if a patient asks you not to send diagnosis or treatment information to their insurance company?
- Do you have parental or family involvement for addiction medicine patients who are age 14-17?
  - Authorizations?
  - What defines a patient's family?
- How would you handle talking with a parent or family member about a 17-year-old's addiction medicine treatment when the patient is about to turn 18 years old?

Questions to Think About continued…

- FERPA-Family Education Rights and Privacy Act
  - Is the student under 18 years old?
  - School based health center?
  - Does the school hold itself out as providing an addiction medicine treatment program?
- Are the treatment records considered to be educational records?
- HIPAA FERPA records
  - Does the school bill insurance?

Questions to Think About continued…

- What's your process to have your patients sign an authorization for the release of their addiction medicine treatment information for TPO?
- How do you identify patients involved in addiction medicine Tx program in the patient's medical record?
  - Separate records?
  - Access controls for EHRs?
- How do you share Part 2 information with the patient's PCP?

Contact Information

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Telehealth Lunch Discussion

Amy Fellows, MPH, Health Connect, LLC/Pivot Point Consulting
Amber Clegg, LPC, CADC III, Deschutes County Health Services

Telehealth Platforms

COVID has been a game changer with telehealth visits now being covered by insurers

Many products have emerged (not an exhaustive list):

- -zoom integration
- -doxy
- -Amwell
- -pexip
- -klara
- -avizia
- -snapMD
- -Mend VIP
- Microsoft teams
- -OnCall Health
- -VSee
- -CarePaths
- -Genoa
- -TheraNest (private practice therapist product with telehealth and billing, scheduling components)
- -FaceTime (for Iphone/Apple users)
- -Web Ex and Zoom stand alone (limiting length of free meetings now)

Navigating Telehealth

- Most common platforms used by this group
- Pros/Cons of some of the telehealth platforms (phone, video, etc.) and using EHR to support your telehealth.

- Questions:
  - Which platforms are you finding that are the easiest to use?
  - How did you set up the platforms for staff and clients to use them?
  - Are you providing services by phone?
  - If you're on EPIC, are you using their embedded Zoom feature?

Support for Staff

- Questions
  - How did you help ensure staff had what they needed to do telehealth?
  - How are you supporting your staff if they are having difficulties navigating virtual platforms?
  - What are you doing if staff are experiencing technological challenges while working remotely?

Support for Clients

- Questions:
  - What are you doing if a client is not able to use a video platform or doesn't have a phone?
  - What if a client is not in a private space?

Ethical Considerations

- Questions:
  - How are you completing intake packets, getting informed consent and obtaining ROI's?
  - What are you sharing with clients about telehealth informed consent specifically?

Other Considerations or Questions?

Thank you for your time!

Amy Fellows: fellowsa@gmail.com

Amber Clegg: amber.clegg@deschutes.org

The Collective Platform & Behavioral Health

Collaborating for the Benefit of Every Patient

September 21, 2020

Ian Bruce, LPC
Clinical Solutions Lead
ian.bruce@collectivemedical.com

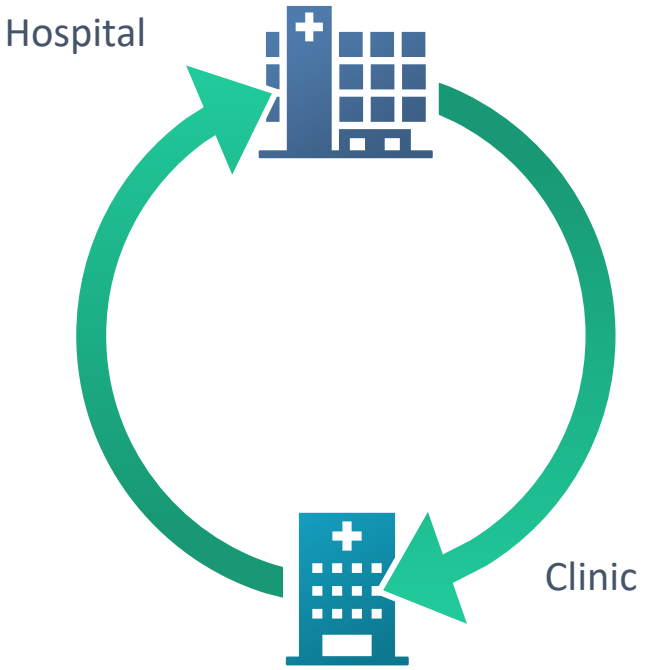
collectivemedical®

Better BH/SUD Coordination through Real-Time Network Collaboration

The Collective platform works in real-time, which means whether you're in a hospital ED, BH/SUD clinic, or other healthcare facility, you can receive up-to-date Insights into the status of your patients.

Hospital ED

- Receive real-time notifications on your most complex patients; delivered to existing workflow
- Ability to coordinate, collaborate, and share insights with care team members on the Collective Network
- Pt specific information related to prior encounters, dx, or other care insights help to inform providers and improve patient care; improved patient and provider safety



BH/SUD Clinics

- Gain real-time visibility into patient hospital encounters— without having to call around or rely on patients to report the hospital visit
- Surfaces events of interest with optional real-time push notifications
- Contribute care insights and crisis plans to collaborate with other care team members, including ED staff, on the Collective Network.

Collective's CONSENT

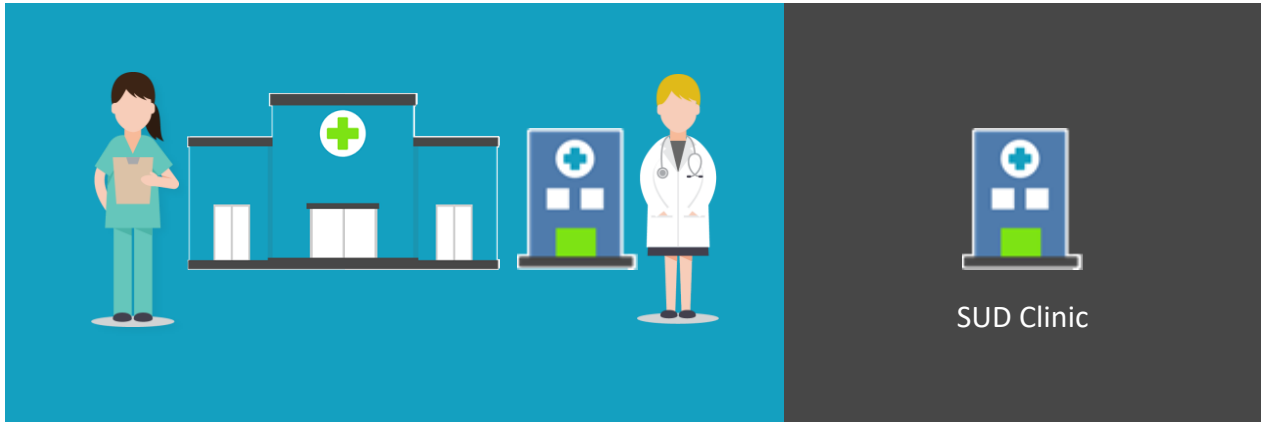
42 CFR Part 2

42 CFR Part 2 is an added level of privacy for patients with relationships with SUD clinics

Key Points:

- Added restriction to information sharing for SUD clinics
- In Addition to HIPAA
- Exemption: SUD information entered by ED

Entire Cross Continuum



HIPAA: Need TPO Relationships

42 CFR Part 2: Need Consent

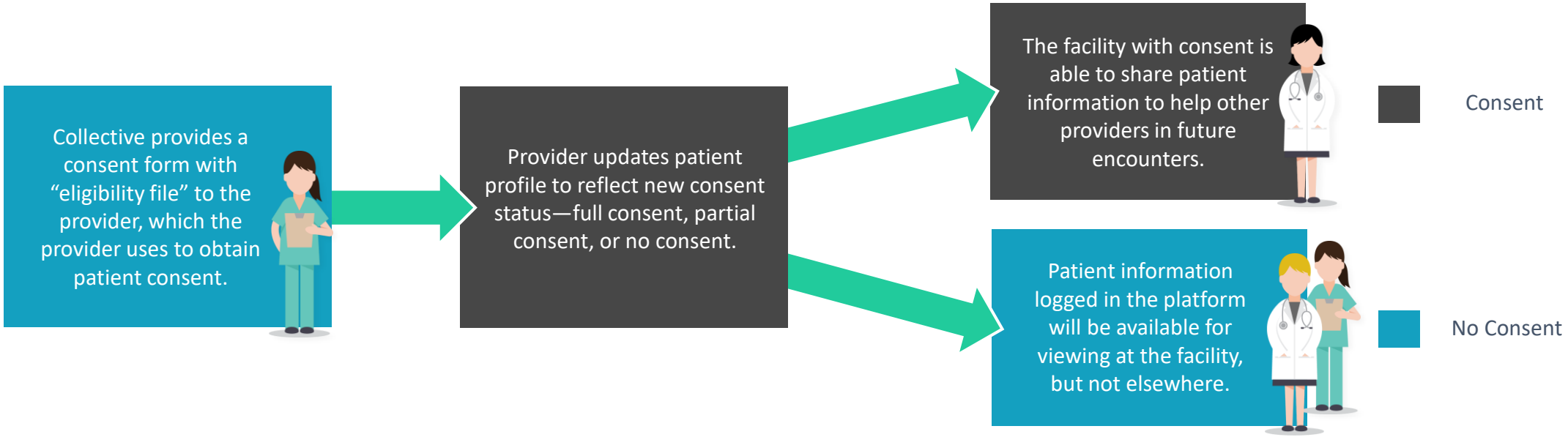
Providers who treat patients with substance use disorder (SUD) cannot share key information across their Provider Network

Using a Technology Solution to address this gap:

- Users can participate in a **consent program** to help facilitate better patient care through collaboration—**without compromising patient privacy**.
- Providers can share **insights, encounters, and care team members** across a Network for those previously siloed patients
- Other members of the Care Team have **access to key insights for collaboration** that previously were unavailable
- A Consent Program allows consent to be **managed by each provider organization** with a **three tiered system** based on the patient's comfort level (full, partial, no consent)
- All information is tagged so **if consent is revoked, the information is hidden** from the user until Consent is re-granted by the patient

Consent—How it Works

"Sensitive Information" was never meant to be "Siloed Information." But in most cases, granting consent only gives a provider permission to share patient information with another specific provider organization. With the Collective Platform's consent format, behavioral health information can be shared when it's needed, with the providers who need it—all while remaining within the revised guidelines set by SAMHSA.

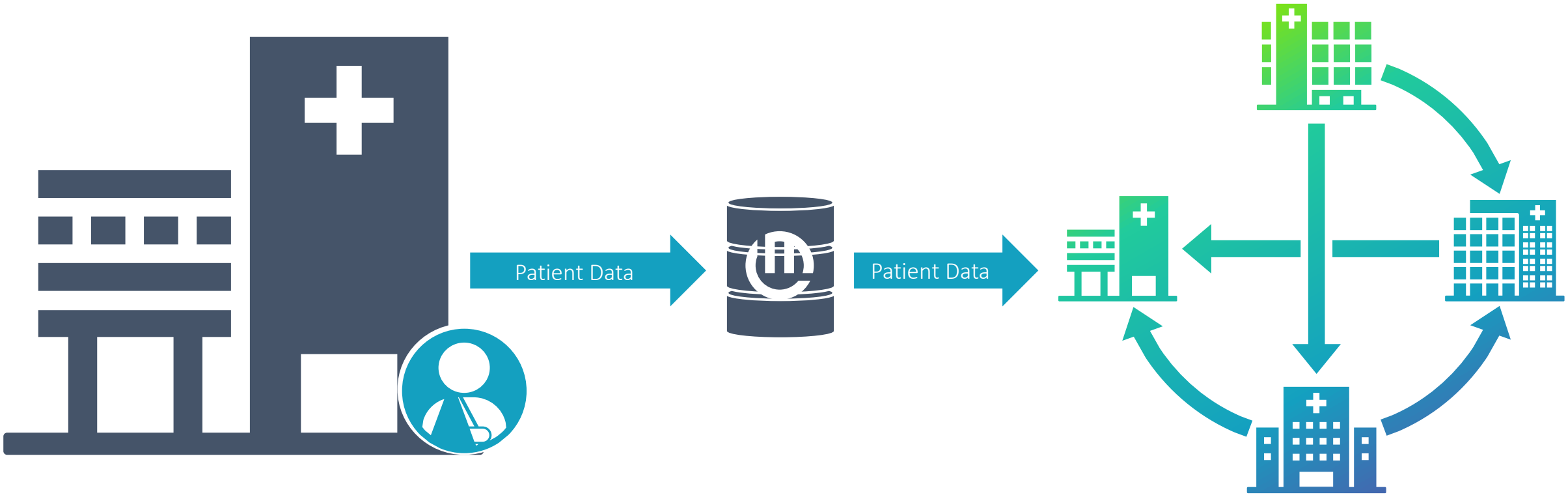


Consent Form

Standard Collective Medical Consent Form

- Allows for the sharing of information across the Collective network
- Managed by each provider organization
- Prevents information from being shared with to health plans
- Allows for the sharing of full, partial, or no clinical information based on type of consent granted

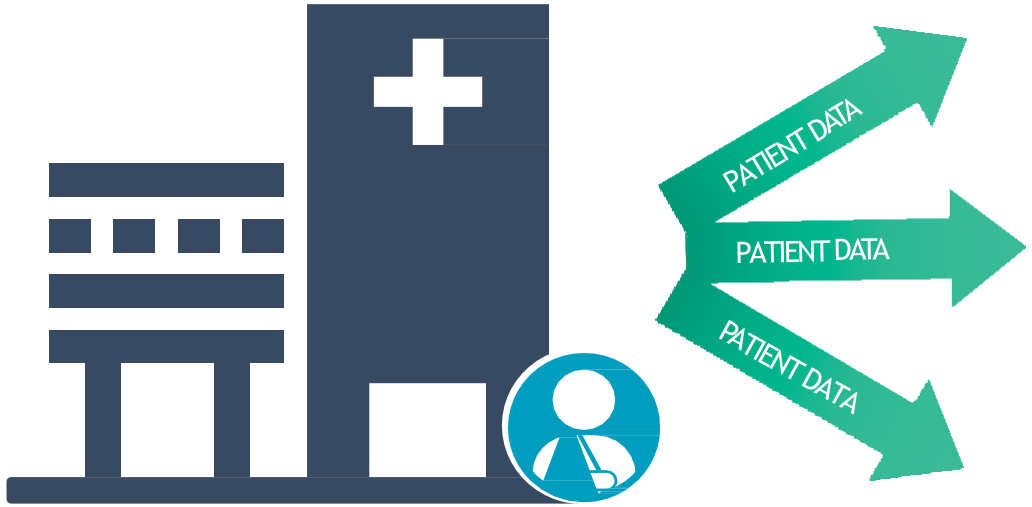
Data Managed Under HIPPA



All other information is managed in accordance with HIPAA and housed within a portal that is default visible to other subscribers in the Collective Network that have a treatment, payment, or health care operations relationship with the patient who is the subject of that information.

Consent Process

For a facility that utilizes Collective's consent model, the sensitive information of that facility may be disclosed via the Collective Network only where the facility has indicated, via a consent message, that it has obtained the patient's consent to do so. There are three types of consent messages: No Consent, Partial Consent, and Full Consent.



DEFAULT SETTING FOR CONSENT ENABLED PORTAL
All sensitive information from a facility using Collective's consent model is housed within a separate consent-enabled portal, making the facility's relationship to the patient invisible by default to the rest of the Collective Network.

PARTIAL CONSENT
Only the facility's relationship to the patient and any encounters at this facility are shared via the Collective Network to the patient's other treating providers.

FULL CONSENT
The facility's relationship to the patient, the patient's encounter history at this facility, and any other content generated by this facility on the Collective Platform are shared via the Collective Network to the patient's other treating providers.

What Changes Are Needed

Eligibility File

- Discuss internally if the cadence of your File submission reflects the appropriate turnover of consent within your patient population.
- Three additional columns will need to be added to your File: ‘Consent’, ‘Date of Consent’, and ‘Date Revocation of Consent’.

Workflow

- NOTE: If a patient’s consent is initially revoked via the Collective portal, since the Eligibility File is the ‘source of truth’ that workflow must also ensure that the File is updated to reflect that patient’s request to have consent revoked.

Transitions of Care for Patients receiving Medication-Assisted Treatment (MAT)

Hospital-to-Clinic Handoff & Outcome Reporting

collectivemedical®

How do hospitals & clinics facilitate transitions and measure outcomes?

Access, Process Reporting, and Outcome Metrics for OUD/SUD Patients

Emergency departments seek to utilize the period of lucidity during buprenorphine treatment as an opportunity to refer patients to medication-assisted treatment (MAT) providers in dedicated treatment settings or federally qualified health centers.

Acute Hospital

patient arrives at hospital with withdrawal symptoms

Patient is prescribed medication to treat symptoms; patient given referral to MAT program

OUTCOME?

- Successful discharge and treatment initiation?
- Timely outreach from MAT clinic to patient?
- Patient still attending treatment at MAT clinic?
- No outreach from MAT clinic to the patient?
- Decreased readmission of patient's with referral? Decreased ED utilization?
- Opioid related mortality?

APPENDIX

If you have already onboarded on to the Collective platform and would like to leverage these additional features please reach out to support@collectivemedical.com

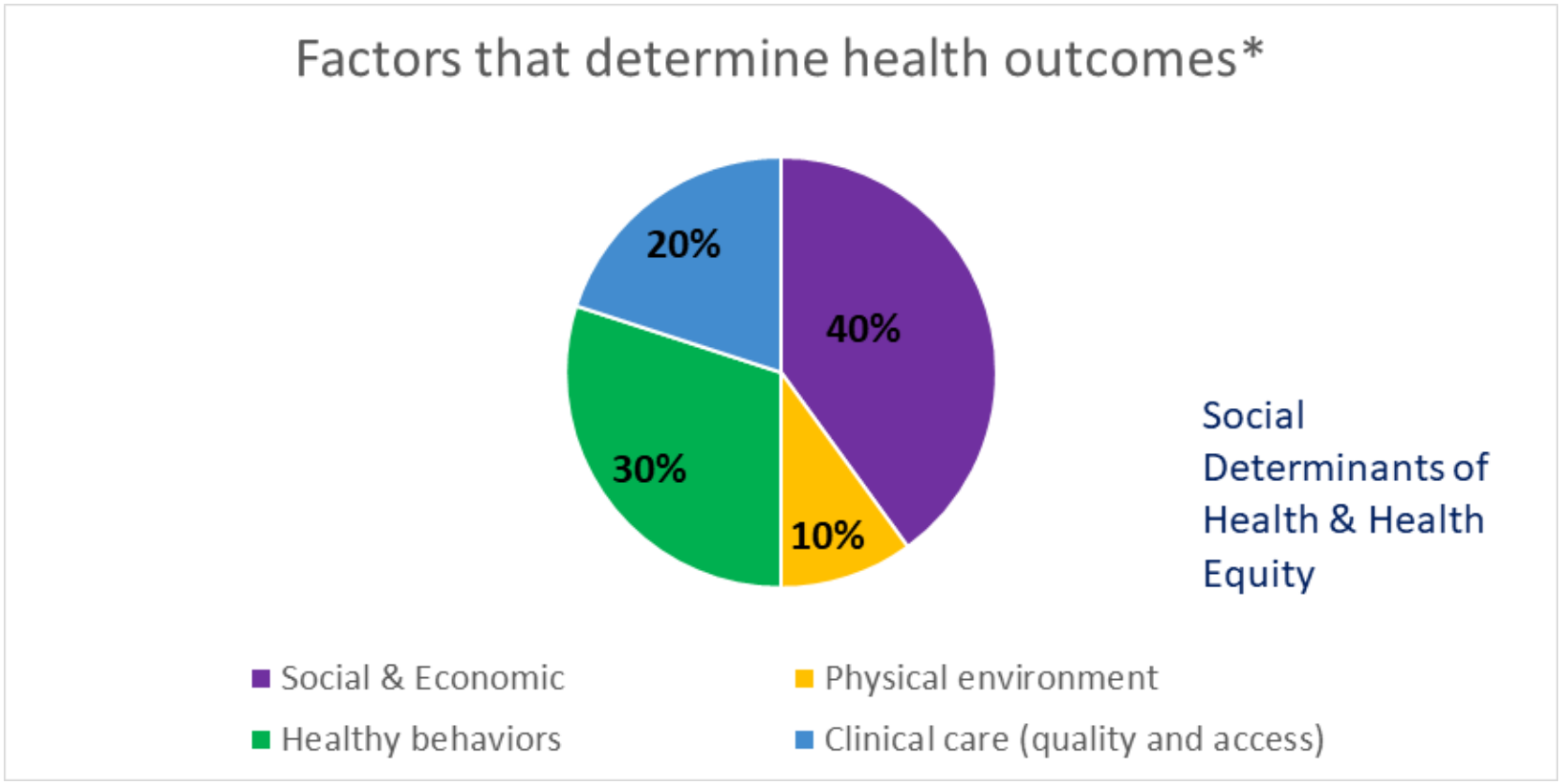
If you haven't yet and would like to onboard on to the Collective platform please also email support@collectivemedical.com and they will help to get you started and answer any questions.

What's Coming? Community Information Exchange
September 21, 2020 BH Community Collaborative

IN PARTNERSHIP WITH

OREGON HEALTH LEADERSHIP COUNCIL | Oregon Health Authority

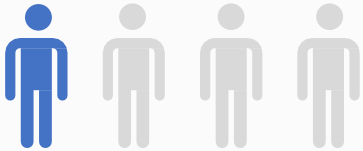
Why Focus on Social Determinants of Health (SDOH)?
SDOH accounts for up to 80% of health outcomes



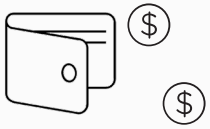
Source: County Health Rankings Model. University of Wisconsin Public Health Institute. 2014.
*This model does not include biology/genetics.

Addressing Social Needs Can Improve Health Outcomes

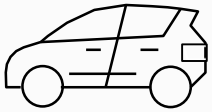
In fact, **one third** of all Americans experience stress relating to social needs



1 in 4 AMERICANS
have had an unmet social need they say was a barrier to health in the past year



21% FUNDS
21% prioritized paying for food or rent over seeing a doctor and/or paying for medication



17% TRANSPORT
17% couldn't go to the doctor / pick up medication because they lacked transportation

9% HOUSING
9% couldn't see a doctor regularly because they lacked stable housing

Source: Kaiser Permanente Social Needs In America Survey, 2019

Aligns with Oregon Priorities

- Oregon health system transformation to address social determinants of health (SDOH):
  - Oregon Health Policy Board focus
  - CCO 2.0 SDOH requirements
  - HB 3076 Community Benefit (includes SDOH for hospital/clinic spend)
  - HIT Oversight Council's strategic planning work
- Oregon health systems, CCOs and communities starting to invest in SDOH infrastructure, or "CIE"
- HIT Commons tracking these developments

Community Information Exchange (CIE)*

- A CIE connects health care, human and social services partners to improve the health and well-being of communities and address health disparities and health equity
- A bi-directional CIE Technology Platform could provide many functions, including statewide social services directory, shared risk assessment capabilities, real-time closed loop referral management, collaborative care coordination, and standardized metrics, and data analysis.
- For Oregon, a statewide effort could include technology components, areas for alignment across different technologies, and areas for collaborative learning.

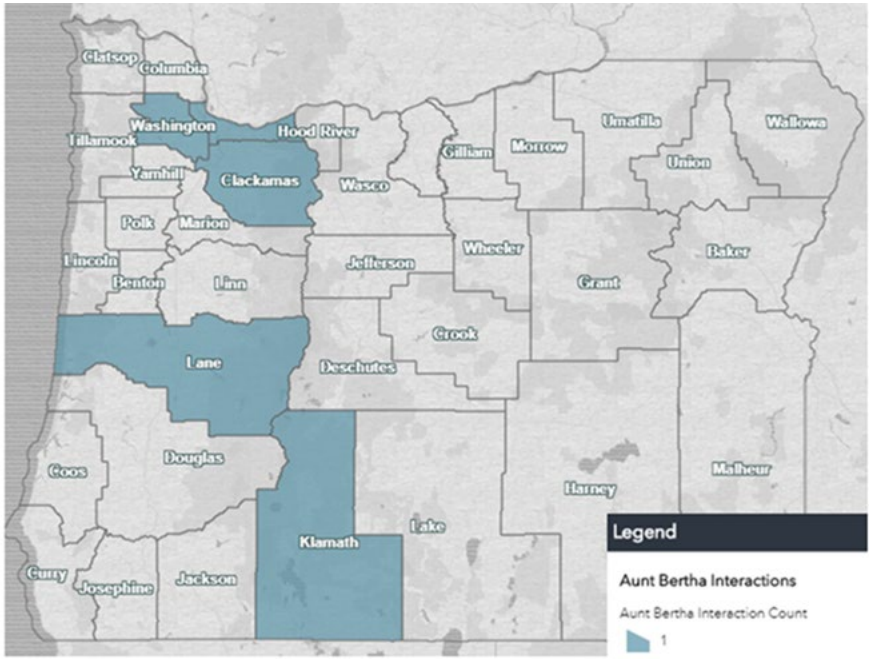
** Working definition in this rapidly evolving space*

Where is CIE happening in Oregon?

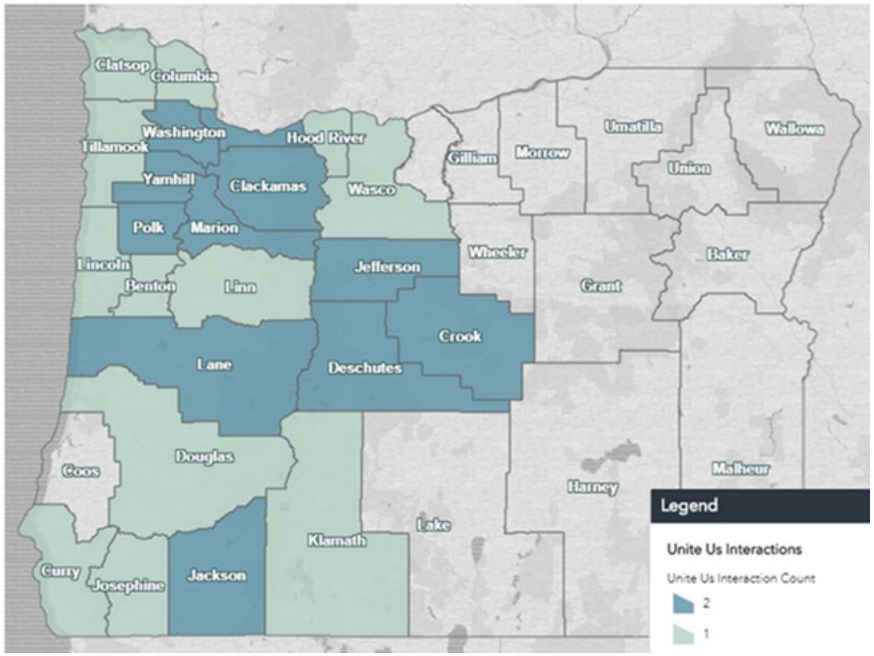
HIT Commons worked with PSU Population Research Center to create a set of working maps: https://pdxedu.maps.arcgis.com/apps/MapSeries/index.html?appid=a9b4fbd305094c769387127521b6250e

CIE Vendor—Counties at some stage of implementation (mostly led by CCO investments)

Aunt Bertha by County



Unite Us by County



Other Efforts:

Activate Care – Coos/Curry

Douglas County Network of Care – Douglas

CIE Implications for Behavioral Health

- Most CIE platforms in Oregon are HIPAA and 42 CFR Part 2 compliant
- Most platforms have detailed processes for managing client consent—but don't replace org-specific consent and clients can revoke consent at anytime
- Platforms control access to sensitive data through user roles and permissions or defer to individual clients to share access to their records
- Special attention is needed to BH providers and their workflows during onboarding and training on CIE

To Learn More

- Many CCOs in Oregon are contracting for CIE platforms
  - Outreach to your CCO contacts to find out about timeline/onboarding
- For help with CCO CIE contacts, please email:
  - Liz Whitworth liz@orhealthleadershipcouncil.org

THANK YOU

http://www.orhealthleadershipcouncil.org/hit-commons/

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