



## BEHAVIORAL HEALTH AND INTEROPERABLE ELECTRONIC HEALTH RECORDS ISSUE PAPER

### Problem Statement

As Ohio joins the rest of the country in moving toward the goal of having all health care information exchanged electronically, the behavioral health care field needs to make sure we are part of this movement. The behavioral health community can no longer continue “as an island” separate from primary health care, hospitals, and other health care providers. To better serve our clients, their behavioral health care information needs to be part of the Electronic Health Record (EHR) along with primary care and other health care providers. We also need to be at the table advocating for funding resources and incentives for the technology and consulting needed to accomplish this major national and international system transition.

This effort will require a strong unified commitment, beginning with a public/private collaborative that has all relevant entities involved in the funding or provision of behavioral health care working together. This collaborative includes consumers, families, state agencies, providers and county authorities. Commitment of resources and funding will be necessary to first, help all behavioral health care providers transition to electronic health care records and second to insure that their EHRs are interoperable with each other as well as all other health care data systems (primary care, hospitals, pharmacies, payers, managed care organizations, etc.).

Three top provider concerns in a recent survey of Ohio Council members are: (1) The need to work for integration between federal, state and local board data formats and requirements for EHR transition efforts, (2) The need to find and advocate for state and federal funding to assist providers in EHR initiatives, and (3) The need to develop a priority list for the standardization of data elements and data functions (i.e., eligibility, remittance, UCI’s billing, wait lists, clinical records, etc.).

Governor Strickland’s recent Executive Order 2007-30S establishes a State level “Health Information Partnership Advisory Board”. This Board is charged with recommending ways the state can improve the flow of data among patients and providers and with developing an operational plan to do so. This plan will include a business proposal to create a public/private organization to coordinate a strategy for using electronic health records and information. The plan will help guide legislative and regulatory actions, maximize federal funding for information technology, identify obstacles, and address the privacy and security of health information.

There are currently many obstacles or barriers to seamless interoperability of health care records for providers. Key issues facing the Ohio behavioral health care system in transitioning to EHR include:

1. Behavioral health is not considered part of mainstream health and therefore our services are not included in design and development of national standards that pertain to Electronic Health Records, such as the Continuity of Care standard recently developed by HL7<sup>1</sup>.
2. The need for the newly created “Health Information Partnership Advisory Board” to act as a statewide “oversight” office or group to set the course and provide the linkage for the diverse groups involved in making critical decisions surrounding transitioning to EHR.
3. There is as yet not an accepted standard definition of an “EHR” nor is there a mandated clear set of definitions of terms within state and federal law surrounding the EHR.
4. Interoperability of existing health and behavioral health care records, across entities and across disciplines is a major challenge for behavioral health, probably more so than medical health because we have traditionally considered our services to be somehow unique or different than those of medical health.
5. There has not yet been any federal or state level funding allocated for providers to help pay for what will no doubt be heavy costs related to transitioning to EHR. These related costs are not built into current provider payment rates.
6. There are no consistent, system wide national, state and local technical standards for providers and vendors; so that when a provider purchases software or other related technology there is no assurance that it will meet the standards required. (CCHIT<sup>2</sup> is attempting to fill this void.)
7. There are as yet no mandated clear definitions of terms with state and federal law surrounding the EHR.
8. There is still an ongoing debate over who owns health data: the client, the provider, or the payer.
9. Data privacy concerns related to health information exchange, including HIPAA compliance issues, are still being debated and there is little or no enforcement of existing rules.
10. Data security concerns related to health information exchange, including HIPAA compliance issues, are also still being debated and there is little or no enforcement of existing rules.
11. There are concerns about the intersection of MACSIS with EHR standards, policies, and regulations. The transition to MACSIS and then HIPAA was very difficult and costly for most providers. There is continuing concern of yet another transition which no doubt will require reengineering and training once again.
12. There are many issues of concern to providers surrounding the MACSIS billing and claims system that need to be addressed prior to transitioning to EHR, including:
  - MACSIS is still not completely HIPAA compliant as far as eligibility and enrollment. Providers cannot yet obtain this information using the HIPAA mandated process.

- i. Lack of compliance with 835 standards. (Electronic Remittance Advices).
  - ii. Lack of compliance with 270/271 standards. (Eligibility)
  - iii. Lack of compliance with 276/277 standards. (Claims Status)
  - iv. Lack of compliance with 834 standards. (Enrollment)
- There is no statewide standard billing function and process.
    - i. Boards deviate from standards on a Board by Board basis.
    - ii. Reimbursement and remittance advice processes vary dramatically across the state.
  - There is no standard state and local board electronic remittance and status of claims rejects (receiving and applying EOB (explanation of benefits) data).
    - i. Boards deviate from standards on a Board by Board basis.
    - ii. Although HIPAA compliant 835 (Electronic Remittance Advices) are provided to the Boards, they routinely do not use them which creates AR reconciliation issues for most providers.
  - There is no standard electronic enrollment process (the collection and/or sharing of information regarding the funding/reimbursement options for persons served).
    - i. The Boards and MACSIS do not accept standard 834 enrollment records.
    - ii. This creates significant manual processing of enrollment and eligibility data.
  - There is no plan for MACSIS policy changes which includes: rationale for changes, communication of changes to all involved parties.
    - i. There is no formal change control process in place.
    - ii. MACSIS evolved without formal administrative rules and processes in place.
    - iii. Even after ten years of operations these rules have not been created.

13. The multiple county board system in Ohio allows multiple interpretations of requirements that providers must meet, especially if they are serving clients from several board areas, leading to costly multiple operational systems which must be maintained by providers in order to get paid.

14. There have been at least eight Regional Health Information Organizations initiated throughout Ohio that are in various stages of development. None of these RHIOs are specific to behavioral health and none of them have included behavioral health care organizations as partners in exchanging health information.

#### Recommendations

1. The newly created “Health Information Partnership Advisory Board” (HIPAB), should be the authority for the core standards for clinical EHRS and technical standards for software and hardware vendors, including prioritizing the standardization of data and data functions. This Board should also provide the linkage for the diverse groups involved in making critical decisions surrounding transitioning to EHR.
2. One major function of the newly created “Health Information Partnership Advisory Board” should be to advocate on all levels, federal, state and local, for funding resources for providers to help pay for the heavy costs related to transitioning to EHR.

3. Another high priority of the HIPAB should be to facilitate as quickly as possible the implementation of the new Medicaid Information Technology System (MITS), the replacement system for the antiquated Medicaid Management Information System (MMIS). MITS will be more than a claims processing system, it is a business transformation project that will result in significant process improvements, accountability, information access and improved metrics for program management. The MITS system needs to include designs for integration with Electronic Health Records at the state and federal level.
4. Establish linkages and participate at the federal and state level to ensure that behavioral health clinical records are included as part of the client "Electronic Health Record" record. This would include advocating that behavioral health clinical data be included in the design of the HL7<sup>1</sup> Continuity of Care Record also known as the Clinical Care Document.
5. Work needs to begin as soon as feasible in making the links with other health care entities to insure the interoperability all health care records, including behavioral health. Health Policy Institute of Ohio has released their report on barriers to interoperability in Ohio and has included behavioral health representatives in the process. The behavioral health system needs to build on this work by continuing to have a presence and voice in decisions surrounding data standards and interoperability. This will be a major challenge for behavioral health, probably more so than medical health, because we have traditionally considered our services to be somehow unique or different than those of medical health.
6. Link with and participate in the efforts of the standard setting organizations to define an EHR that includes behavioral health clinical data, so that there are consistent, system-wide national, state and local technical standards for providers and vendors. When purchasing EHR software or other related technology, providers need assurance that it will meet the standards required.
7. Participate in establishing clear definitions of terms within state and federal law surrounding the EHR.
8. Participate in the debate and resolution of the issue concerning ownership of EHR information.
9. Advocate for federal resolution and dissemination of privacy concerns related to health information exchange, including HIPAA compliance issues.
10. Advocate for federal resolution and dissemination of security concerns related to health information exchange, including HIPAA compliance issues.
11. Establish consistent, standard requirements that must be adhered to by providers and all county and state authorities. This would alleviate the multiple interpretations of requirements that providers must meet, due to the Ohio multiple county board system. Providers serving clients from several board areas should have a standard way to submit data in order to get paid.
12. Identify the issues surrounding the intersection of MACSIS, SOQIC and BH Mod with EHR standards, policies, regulations, early in the transition process. This should help mitigate the myriad of costly issues encountered by the system, especially providers, when they transitioned to MACSIS and then HIPAA. In the national and statewide debates concerning the structure and policies surrounding EHRs, care must be taken that policies do not interfere with providers' ability to move toward this goal.

13. In the interim prior to transitioning to the MITS system, MACSIS rules must be put in place to create statewide consistency and to bring MACSIS into compliance with HIPAA requirements, which will enable better accounts receivable management for providers. MACSIS already has the capability to produce HIPAA compliant reports designed to assist providers with timely processing of claims. Rules must be created to make sure that eligibility, enrollment, status tracking, and electronic remittance reports are available to providers as was intended by the HIPAA legislation.
14. Explore the feasibility and efficacy of establishing and supporting a behavioral health RHIO which would provide linkages between providers and with other primary health care providers, managed care plans, Federal Qualified Health Care Centers, county boards, and state/federal agencies. This BHRHIO would provide the infrastructure to process standard HIPAA compliant transactions and set the stage for the exchange of standard EHR transactions for the entire behavioral health community. There are many initiatives currently underway in Ohio to address the EHR issues, including state initiatives, private providers, state run hospitals, private hospitals, primary health care providers, managed care organizations, and numerous other health care related organizations. There have been at least 4 RHIOs formed in Ohio in the past few years, none of which as yet include behavioral health care providers. Due to the unique nature of the behavioral health community, that has a long history of working together, there is a synergy that would make the development of a single state wide behavioral health RHIO a distinct possibility. This BHRHIO would provide clinical data exchange between community providers, primary care providers, managed care organizations, and state and private hospitals through a single entity. This same infrastructure would be used to enforce HIPAA compliance with existing administrative transactions. Therefore, the vision is a single portal that would connect the entire Behavioral Health community based on data standards and interoperability standards.

## Summary

The goal in behavioral health care should continue to be quality care for consumers. To accomplish that goal, behavioral health care providers must now view themselves as an integral component of the client's overall care and part of the client's Electronic Health Record. EHRs and their promise of data standardization and interoperability between all facets of health care should be viewed as one of the most important vehicles to achieve the best and most appropriate care for our clients.

The recent history of Ohio behavioral health care system changes such as the transition to MACSIS and then HIPAA were in many ways cumbersome, inefficient and costly to providers, as well as to the State. With strong leadership, as well as thoughtful planning and coordination, the system can avoid repeating some of the more onerous and costly mistakes in the past by providing clear standards and direction for how Electronic Health Records are to be developed for all aspects of the healthcare community.

As of now, most published definitions of an EHR do not include behavioral health care services. Another important goal must be to change this global view of EHR and make sure that behavioral health is a recognized part of the definition. Behavioral health needs to be perceived as an important part of the clients' Electronic Health Record and therefore part of the healthcare "Continuity of Care".

Endnotes:

1. HL7 - Health Level Seven is an all-volunteer, not-for-profit organization involved in development of international healthcare standards. "HL7" is also used to refer to some of the specific standards created by the organization. HL7 and its members provide a framework (and related standards) for the exchange, integration, sharing and retrieval of electronic health information. The standards, which support clinical practice and the management, delivery, and evaluation of health services, are the most commonly used in the world.
2. CCHIT - The Certification Commission for Healthcare Information Technology is a private not-for-profit organization that serves as the recognized US certification authority for electronic health records (EHR) and their networks. CCHIT was founded in 2004 with support from three leading industry associations in healthcare information management and technology: the American Health Information Management Association (AHIMA), the Healthcare Information and Management Systems Society (HIMSS) and the National Alliance for Health Information Technology (the Alliance). In September 2005, CCHIT was awarded a 3-year contract by the U.S. Department of Health and Human Services (HHS) to develop and evaluate the certification criteria and inspection process for EHRs and the networks through which they interoperate. In October 2006, HHS officially designated CCHIT as a Recognized Certification Body (RCB).

3/11/08