ILHIE ILLINOIS HEALTH INFORMATION EXCHANGE

The Illinois Case Study:
Behavioral Health & HIT Readiness

Illinois Office of Health Information Technology
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Dia Cirillo is the author of this white paper and served as the project director for the Illinois Behavioral Health Integration Project.

Introduction

Significant federal outlays have been invested in the adoption of electronic health records (EHR) systems[1] and the advancement of state health information exchange (HIE) efforts since the passage of the Affordable Care Act (ACA), the federal HITECH Act of 2009, and subsequent state authorization in 2010. In these last few years, doctors, hospital systems and states are making substantial strides towards electronic health record adoption, meaningful use stages and heath information exchange.

The transition away from paper-based medical records to an electronic platform for health record management and consultation seeks ultimately to support a new design of the American healthcare system that aims to improve health outcomes by integrating behavioral health services (specifically mental health and substance use treatment) with medical services and focusing on patient-centered care. Through care coordination, electronic data sharing and ultimately payment restructuring, this approach seeks to rein in costs.

Of its many provisions, the ACA ushers in health insurance parity for behavioral health services, and for the first time, Americans will have the potential to receive behavioral health services on par with medical services, and reap the health benefits of care coordination and integration. Behavioral health is now intimately tied to wellness, since 29% of adults with a chronic medical condition have a co-occurring mental health disorder, and 68% of adults with a mental health disorder have a co-occurring medical condition[2]. An analysis of the Illinois Medicaid population shows that 43% of the adult population have a chronic medical condition, 33% have either a mental health or addiction disorder, and 22% experience the co-occurrence of a behavioral health disorder and chronic medical condition.[3]

Electronic data sharing is the bedrock to care coordination since it allows for the simultaneous consultation on a patient's record by providers located at different sites and across specialty areas. Yet, incentives for EHR adoption target the medical community and generally have not benefitted the behavioral health community, unless and except when a psychiatrist seeks to serve as the eligible professional or when there happens to be a nurse practitioner on staff. What remains to be seen is how the historic and current divide between medical care and behavioral services is bridged in terms of care integration.

Siloed care has long been the operating modality of the American healthcare system, given fee for service payment structures and preferences for specialized rather than general care.[4] Any behavioral health services sought by an individual has typically remained in that sphere. Even with the advent of physicians involved in prescribing psychotropic medications and diagnosing behavioral health disorders, other therapeutic interventions, such as counseling or addiction intervention remains with those specialists.

Further, the privacy laws that were developed decades ago to protect the identity of individuals seeking treatment or intervention are now in the process of being re-considered in light of policy imperatives that aim to accelerate electronic data sharing and care integration. A central challenge to this process is that these laws were developed for several reasons, including and especially to protect against stigma or discrimination, and pre-date the evolution in health IT.

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[1] $15.8 billion as of July 2013. www.cms.gov/EHRIncentivePrograms. An estimated $27 billion will be spent over 10 years.
[2] Robert Wood Johnson Foundation. *Mental Disorders and Medical Co-Morbidity*. Brief #21. February 2011
[3] Illinois Department of Healthcare and Family Services, October 2012
[4] Kellerman, Arthur L. and Spencer S. Jones. What It Will Take to Achieve the As-Yet-Unfulfilled Promises of Health Information Technology. *Health Affairs*, 32, no.1 (2013): 63-68.

Most often, in the context of HIE, four issues are raised as significant challenges for behavioral health providers and their patients: behavioral health services have not benefitted from incentive dollars to convert to an electronic platform; privacy laws are especially restrictive in relation to the sharing of behavioral health information and some have yet to be modernized to allow for the advent of HIE; medical services and behavioral services have historically existed in mutually exclusive worlds; and, individuals receiving behavioral health services have experienced discrimination in the medical arena.

In the case of Illinois, what became evident is that there exists a strong commitment within the behavioral health arena to participate in and advance the state of affairs in relation to adopting electronic health record systems and even redeploying services to allow for greater coordination with medical providers. This emerging picture became apparent through two surveys and focus groups[5] conducted in 2012 in Illinois and the implementation of a strategic initiative[6] expressly to bring behavioral health providers into the Illinois Health Information Exchange (ILHIE).

Furthermore, Illinois's experience has shown that behavioral health providers are adopting EHR systems that allow them to meet meaningful use core measures and collect incentive dollars. These providers are also sharing patient data electronically and replacing the fax with ILHIE Direct, a secure, encrypted email service for health purposes. As a result, these providers have experienced significant time savings in the delivery of service. Having the right information at the right time is now a reality for behavioral health.

Illinois Behavioral Health Providers – A Cohort ahead of the Rest

What became evident over the course of 2012 is a cohort of behavioral health providers in Illinois had already adopted EHR systems, met meaningful use core menu items, and received incentive dollars. Data from the surveys and focus groups[7] provided a clear picture of how this cohort is in the process of changing the shape of service delivery in Illinois today by adopting and adapting to health IT.

EHR Adoption

The random survey conducted on behavioral health organizations readiness for health IT in Illinois produced an 18% response rate[8]. Providers demonstrated that they had adopted EHR systems at 39%,

[5] Behavioral Health Work Group of the ILHIE. Illinois Behavioral Health Organization Health Information Technology Survey, 2012. Unpublished.
Illinois Office of Health Information Technology. Provider Focus Groups and Surveys, 2012.

[6] Illinois Behavioral Health Integration Project, which was funded under the CIHS-HIE national demonstration program, administered by the National Council for Behavioral Health, grant number 1UR1SMO60319-01, -02 and supplemental grant number 3UR1SM060319-02S1 from SAMHSA/HRSA, U.S. Department of Health and Human Services

[7] Approximately 133 unduplicated organizations attended and there were161attendees. One-hundred and twenty individuals submitted responses to the survey conducted during the focus groups. Focus groups were held in Rockford, Chicago, Springfield and Southern Illinois (Carterville, just outside of Carbondale). Thirty-six percent of attendees were from organizations combining mental health and addiction services; 34% strictly provided mental health services; eleven percent only provided addiction services; another 3% represented mental health programs at medical facilities and the remaining 16% represented other organizations, such as the courts, juvenile facilities, etc. Fifty-nine percent of survey respondents held a license in behavioral health. Sixty-eight percent were decision-makers at their organizations and held positions in the C-suite or as clinical or administrative directors.

[8] In February and March 2012, the Behavioral Health Work Group of the ILHIE Advisory Committee surveyed 700 behavioral health organizations on HIT readiness. This universe included state funded and licensed mental health and substance use treatment providers as well as the full membership of the Illinois Psychiatric Society. This survey was conducted via email involving 54 questions and achieved an 18% response rate of 128 providers participating. Participants were 41% combined mental health and substance use treatment programs, 23% mental health programs, 15% substance use treatment and 21% other. Survey results are weighted towards providers on email. Geographic representation covered both urban and rural areas with 51% of organizations providing services in urban areas, 33% in rural areas and 16% in both areas.

with close to one quarter having fully implemented a system, and the remaining portion with a partially implemented system. In 2012, medical provider rates of adoption for a basic system were reported as 40% in a *Health Affairs* article[9] and for primary care physicians it was 42.5%[10]

Behavioral health providers that have had systems implemented are often operating with less than their medical counterparts in operating funding specifically for health IT initiatives. In fact, they often designate just 2% or even 1% of the organizational budget, which is approximately at least 30% to 50% less. So when these same providers identified resources as the number one barrier to funding these initiatives they are intimately aware of how difficult it is to make these initiatives work with limited resources.

Yet, an additional 31% of those responding to the survey are in the process of implementing an EHR system. For this sample, this brings the percentage up to seventy for those that have or are implementing an EHR system. Last year, *Health Affairs* reported that 72% of medical providers have some type of electronic health records system.

Meaningful Use Core Measures

Meaningful use is a performance measurement system that determines the extent to which an electronic health record system has been integrated into clinical processes to improve the care and health outcomes of patients in order for select providers to become eligible for incentive funding through Medicaid and Medicare.

There are three planned stages of meaningful use: Stage 1 captures and exchanges patient health data; Stage 2 focuses on advanced clinical processes; and, Stage 3 reports outcomes associated with patient data. In Stage 1, there are fifteen core measures for using certified EHR systems to capture patient information, and ten menu measures that establish the minimum threshold by which to be considered eligible for incentive funding.

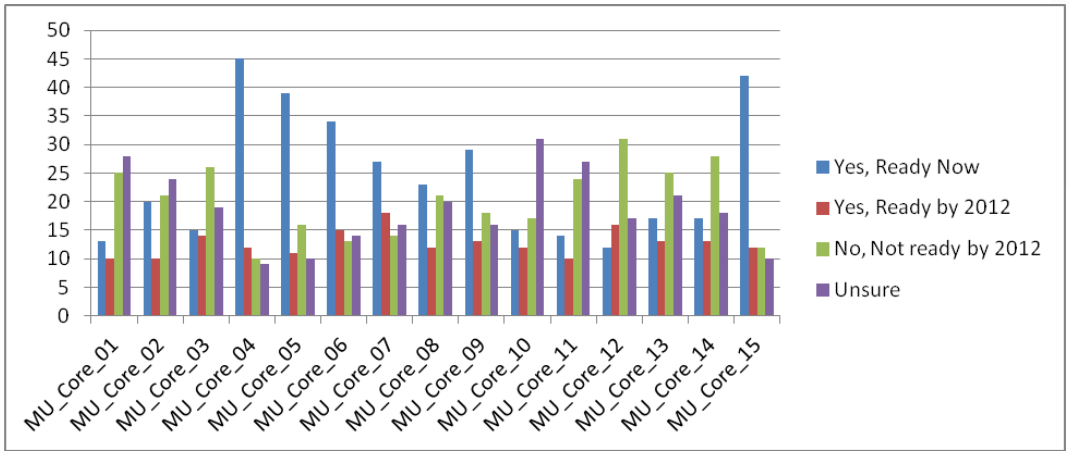
Time is elapsing to attest for the first time for Medicaid and Medicare incentive funding. Seventy percent of respondents indicated that they receive Medicaid funding and 49% indicated that they receive Medicare funding. The first attestation for Medicaid must occur by 2016 and for Medicare it is 2014. Once the first attestation is made on adopting, implementing or upgrading an EHR system, Medicaid providers will have until 2021 to meet all stages of meaningful use and Medicare providers will have until 2015.[11]

Behavioral health providers are currently capable of and have been in the process of implementing capabilities that have functionalities, both in terms of health IT and the practice scope, that allow them to participate in the incentive programs for Medicare and Medicaid. A full 49% of respondents knew whether or not they were able to collect meaningful use incentive payments and 42% were eligible[12]. Fifty percent will be applying for incentive funding by 2014.

These providers are meeting national requirements for utilizing EHR systems and can meet measures associated with general medical services, such as the problem list (core 5), medication (core 6), allergies (core 7) and protecting health information (core 15). Behavioral health providers were able to meet core menu measures in all fifteen categories.

[9] Kellerman, Arthur L. and Spencer S. Jones. "What It Will Take to Achieve the As-Yet-Unfulfilled Promises of Health Information Technology." *Health Affairs*, 32, no.1 (2013): 63-68.
[10] Robert Wood Johnson Foundation. *Health Information Technology in the US: Better Information Systems for Better Care.* 2013.
[11] Centers for Medicare and Medicaid Services, EHR Incentive Programs
[12] In this survey, providers indicate whether their site staff meet the eligible professional criteria.

Figure 1: Illinois Behavioral Health Provider Readiness for Core MU Measure (n=76)[13]



Behavioral health providers had particular success in the following seven categories, showing a low of 30% in recording vital signs (8) and a high of 60% in recording patient demographics (4). The first six of these objectives overlap directly with core measures that medical counterparts typically show high rates of achievement. However, these counterparts are less likely to meet core measure 15, protecting electronic health information. These seven measures form the basis for measures that often comprise basic EHR functions, which reflects foundational capabilities in health IT.

MU_Core_04	Records patient demographics
MU_Core_05	Maintains an up-to-date problem list of current and active diagnoses
MU_Core_06	Maintains active medication list
MU_Core_07	Maintains active medication allergy list
MU_Core_08	Records and charts changes in vital signs
MU_Core_09	Records smoking status for patients 13 year old or older
MU_Core_15	Protects electronic health information

For remaining core measures, behavioral health providers hovered between 17% medication orders (1) and 26% drug interaction checks (2) in being able to meet each measure. While most medical providers are able to meet measures such as e-prescribing (3), ambulatory quality measures (11), and clinical summaries (13) handily, they are also reported as meeting measures on interaction checks (2), clinical decision support (10) and exchange (14) at lower rates.[14]

MU_Core_01	Uses CPOI for medication orders
MU_Core_02	Implements drug to drug and drug allergy interaction checks
MU_Core_03	Generates and transmits permissible prescriptions electronically (eRx)
MU_Core_10	Implements one clinical decision support rule
MU_Core_11	Reports ambulatory clinical quality measures
MU_Core_12	Provides patients with an electronic copy of their health information

[13] Illinois Behavioral Health Organization Health Information Technology Survey, 2012. Unpublished.

[14] Robert Wood Johnson Foundation. *Health Information Technology in the US: Better Information Systems for Better Care.* 2013.

MU_Core_13	Provides clinical summaries for patients for each office visit
MU_Core_14	Exchanges key clinical information among providers of care

These results show, that despite the financial challenges in meeting meaningful use, behavioral health providers are able to do so with some solid success and understand the extent to which their current and planned capabilities will allow them to meet specific measures. In addition, these providers are largely able to meet the measures for basic EHR functions and capabilities that overlap with medical providers.

Health Information Exchange

Surveys conducted during provider focus groups revealed a strong preference for accessing medical information from the HIE to facilitate current behavioral health services. Of a list of ten pieces of information, the top five in descending order included: medication, diagnosis, medical history, discharge recommendations and allergies. Focus group data corroborates this list and adds labs to the list. There was less enthusiasm for sharing these data to facilitate care coordination or to encourage individuals receiving services to share such information with other providers involved in their treatment. Nevertheless, behavioral health services would be hard pressed to furnish a complete patient record incorporating all of this information representing both medical and behavioral health data elements without the involvement of a physician or other medical provider.

In fact, medical provider was the exchange partner most frequently selected over residential and outpatient mental health and addiction services. Ninety-six percent[15]of attendees had or were planning to implement an EHR system and, second to electronic prescriptions, providers utilized the EHR for the continuity of care. Overwhelmingly, the fax was used to transmit patient health information.

The focus groups also shed light on the service delivery environment and revealed that the majority of providers offered community based outpatient services either making referrals to a higher level of care such as residential or to a lower level of care that involved preventative medical services. Attendees consistently identified the HIE, medical health homes and embedded mental health or medical services as changes that would occur on the three year horizon. Admission, discharge and referral ranked as the top three exchange points.

Patient Privacy & Consent

Several laws govern patient privacy and consent. HIPAA[16] governs general medical information and allows physicians to share patient information for the purposes of treatment, payment and business operations without a patient's express authorization. Sensitive patient health information, such as substance abuse and mental health, require express patient authorization to share with other providers involved in the patient's treatment and care; and that authorization typically specifies the kind of data being shared and the terms of sharing (e.g. to whom, from whom, duration, etc.). The federal regulations 42 CFR Part 2 govern addiction information at designated treatment facilities. State law governs mental health information.

During the provider focus groups in 2012, the discussion on consent was broad in nature and participants were asked to respond to "What is an effective and appropriate process for consent?". Throughout the focus groups, providers indicated that they have a role in consent. When asked who and how should

[15] Focus group attendees responded to an open invitation. This number, while very robust, reflects that the behavioral health organizations that self-selected to participate in the focus groups were most likely to have EHR systems. The BHO HIT survey reports the most accurate measure for EHR adoption by behavioral health providers in Illinois.
[16] Health Insurance Portability and Accountability Act of 1996

patient authorization be solicited, providers most frequently indicated that consent was an essential feature of treatment and should remain the province of providers to manage and implement in partnership with patients.

The focus group discussion regarding consent revealed heterogeneous positions across a broad spectrum spanning patient consent preferences from most restrictive to making health information available fully. Positions on what data to restrict included HIV, substance abuse, domestic violence and therapy notes to an unexpected position of having no data restrictions at all.

Providers identified three distinct positions defining under what conditions patient information should be shared: i) on a need to know basis; ii) for treatment purposes; and, iii) under "granular" choice, by electing which data elements to share with whom at a specific time. In terms of the duration of consent, positions varied from one year, for the period of treatment, as long as necessary, and none at all.

Positions on what changes should be made to the patient consent model fell into three proposed models:

- Existing model: Need to know basis; time limited; granular
- Mixed model: One year duration of consent; blanket consent; no witness; template forms
- Federal standard: Blanket for treatment, payment and operations; global consent forms

For both the focus groups and the HIT readiness survey, the largest group represented were programs offering combined mental health and addiction services, while the smallest group was addiction services. Combined mental health and substance abuse programs were most likely to have shared medical problem lists with physicians, more likely to have an integrated electronic record and most likely to have onsite primary care. In contrast, addiction services were the least likely to have adopted EHR systems.

Combined programs seem to be seeking the integration of behavioral health care with some level of medical services. The consent environment cannot account for the difference in capacity alone among combined programs and single focus ones. At the time of the focus groups, in 2012, Illinois still had in effect a mental health confidentiality act that was more restrictive than federal regulations (42 CFR Part 2) protecting substance abuse information at a designated facility or unit. The willingness to invest in EHR systems and begin a process towards integrating electronic medical records likely reflects the increasing role of physicians in mental health diagnosis and pharmacological treatment as well as a decrease in overall public funding for mental health.

Consumer Focus Groups[17]

Consumer focus groups offered a window onto how consumers thought about consent and their rights for nondisclosure protected by federal and state laws. Participants consistently prioritized access to health care. Substance use treatment consumers especially voiced concerns regarding drug interactions or resistance to general anesthesia. Since consumers indicated that they rely on their existing providers to facilitate referrals to medical providers, they felt that they could trust physicians involved in their treatment. And it was in the consumer focus groups that we learned that substance use treatment consumers appear to have a great deal of curiosity in relation to how physicians can track and coordinate information regarding prescriptions.

[17] In October 2012, four consumer focus groups were conducted: three in-person, targeting specific treatment groups, which included mental health, substance abuse and one mixed; and one on a consumer call hosted by the Illinois Department of Human Services, Division of Mental Health.

When conversations turned towards privacy rights, consumers largely wanted to know what their rights are and where they could find information regarding their rights. Younger consumers stated that they would like to see a website carrying all of this information. Most consumers acknowledged that consent is handled in such a way that they do not even know what they are signing most of the time. What reassures them is that they trust their providers to represent their best interests and interpret these documents for them.

These focus groups revealed that clients understand that electronic transmission replaces the industry's longstanding reliance on fax transmission. Since behavioral health treatment relies on a trust relationship with a provider, focus group participants understood consent in the context of that trust.

Electronic Data Sharing

Despite the earlier finding that behavioral health providers largely utilized the fax to transmit patient health information, behavioral health providers have proven themselves adept at utilizing ILHIE Direct, a secure and encrypted email solution to transmit health information electronically. Since ILHIE Direct offers point to point transmission like a fax, it supports consent requirements for a specified recipient and an auditable trail of transacted information.

In June 2012, the focus group survey showed that despite that 96% of respondents had or were implementing an EHR system, the majority of respondents used the fax machine to transmit health information to an exchange partner. By March 2013, the top users of ILHIE Direct were behavioral health providers and their exchange partners. While some of these organizations had participated in demonstration projects during third quarter in 2012, they still are using ILHIE Direct today and remain its top users.

This behavioral health cohort and its exchange partners represent approximately 5% of all domains on ILHIE Direct. On the whole the highest number of monthly transactions have increased slightly by August 2013 from 189 to 193.[18] Yet, there has been some decline in average monthly transactions for some of the domains in the top fifteen and overall average number of monthly transactions have dropped from 85 to 58. Without additional research, it is difficult to determine the cause of the drop, as it will likely reflect certain idiosyncratic aspects of the programs represented, for example, new staff, new partners or even program changes.

ILHIE Direct utilization is in its infancy. However, through use cases that arose out of demonstration projects, it is clear that it can offer substantial efficiencies for behavioral health providers in their current exchange environments and provide the basis for reconfiguring exchange relationships and redeploying resources to advance towards a care integration model[19]. The actual exchange of patient information in an electronic environment, utilizing ILHIE Direct is not a plug and play opportunity. Rather, for patients and the services to benefit from electronic exchange, there has to be an intentional change management process that identifies specific process change among all providers to achieve sustainable and substantial efficiencies in the practice environment.

[18] ILHIE Direct Reports, March and August 2013
[19] Reynolds, Kathleen, et. al. *Standard Framework for Levels of Integrated Care.* Center for Integrated Health Solutions SAMHSA-HRSA. 2013

Use Cases – Care Coordination and ILHIE Direct

In Illinois, three use cases[20] have been identified that demonstrate electronic exchange of patient health information among behavioral health and medical providers. These use cases grew out of six demonstration projects that Illinois funded in the fall of 2012 for twelve weeks. These projects were selected as use cases for they demonstrated measureable changes, developed a sustainable approach to this change and are still in operation today. They also met a set criteria related to change management, which included: specificity of service focus; leadership support in all organizations; change management and/or work flow adjustments**.**

The organizations demonstrating the use cases include two mental health providers, Mental Health Centers of Central Illinois and Lutheran Social Services of Illinois, and one addiction services provider, New Age Services Corporation.

Table 1: Summary of Illinois Use Cases

Geography	Provider	Type of Provider	Use Case	Efficiency[21]
Central Illinois: Springfield	Mental Health Centers of Central Illinois	MH/SA	Mental Health Triage in Emergency Rooms	36 min/case; ~1200 hrs/yr for 2000 cases
Metro Chicago	Lutheran Social Services of Illinois	MH/SA	Youth in Mental Health Crisis	2 hrs/case; 1540 hrs/yr for ~770cases/yr
Chicago	New Age Services	SA	Medical Evaluation of Methadone Maintenance	On average, 5 days; no longer driving documents

By introducing a new electronic process, Mental Health Centers of Central Illinois (MHCCI) reengineered current relationships among their collocated psych team and the emergency department (ED) staff to allow for shared consultation on patients in the ED. Now the work streams of both entities are more integrated. MHCCI provides an example of care delivery that goes beyond coordination and achieves at least an initial level of integration.

MHCCI leveraged the use of ILHIE Direct to evolve the collocated service model for mental health triage of presenting patients in the emergency department at Memorial Medical Center. Upon introducing ILHIE Direct to facilitate secure communication on mental health patients with Memorial, MHCCI realized that they could shift the patient consent process to the HIM staff at Memorial and free up time that the ED nurses could use toward treating patients. MHCCI also introduced an electronic form for psychiatric evaluation in the ED. The combined effect of introducing ILHIE Direct, shifting consent responsibilities and introducing an electronic assessment produced efficiencies in the amount of 1200 hours of staff time over the course of a year, which provides an overall staffing saving of 60% of a full time employee.

Providing emergency intervention support to youth at risk for hurting themselves or others requires that Lutheran Social Services moves quickly to address each client situation. As LSSI adopted ILHIE Direct

[20] For additional information regarding use cases, link to this website: hie.illinois.gov
[21] Data corroborating these efficiencies comes from reporting provided by these providers during the demonstration project phase.

into this program environment it also provided laptops to the field staff working with clients. This approach saved LSSI staff hours of paperwork, triple entry of forms, and allowed them to consult with clients in the field, access the EHR system remotely, develop a transition of care document and send it to the residential hospital in advance of the client's arrival. By doing so, LSSI saved 1540 hours per year across its case load or approximately two hours per case. This freed up over three-quarters of a full time staff position in relaying case documentation by hard copy and fax.

Similarly, New Age Services also introduced ILHIE Direct in an existing program, medical evaluation of methadone maintenance, and although NASC did not use an EHR platform, they experienced a time savings of approximately five days per case, since they did not have to drive medical evaluations to the medical provider.

These providers experienced significant efficiencies and are able to support a "warm hand-off" with their exchange partners, by ensuring that as clients are transitioned to the next step in treatment, pertinent health information is available to that provider when the patient arrives at the facility. These use cases show how ILHIE Direct aids in perfecting both the existing model of referral and can support evolution towards integration, while creating efficiencies that can allow for treating additional clients or adding new services.

The Illinois Behavioral Health Integration Project (BHIP)

When the National Council awarded Illinois a grant at the beginning of 2012 under the CIHS-HIE funding program to promote and establish electronic exchange of behavioral health data in real time with medical providers, Illinois was the only large state to be selected to participate. At that point, Illinois' efforts to launch the ILHIE were two years in the making and it had just launched its first service, ILHIE Direct, a point-to-point secured and encrypted messaging service. While Illinois Medicaid's first care coordination effort had just launched and several providers in Illinois were recipients of PCBHI funding, there were not any widely known cases of the electronic exchange of behavioral health and medical records in the state, primarily because mental health confidentiality protections, at that time, were very restrictive and did not recognize electronic exchange.

One of the many benefits of being awarded the CIHS grant and participating in the national demonstration of behavioral health data sharing at that point in the ILHIE's development is that the behavioral health community would be engaged at a critical point in the launch and evolution of the ILHIE.

Political complexity is also a hallmark of a large state. Despite the austere fiscal environment in Illinois, the behavioral health stakeholders are broad and robust. In the application for the grant, Illinois included twenty-five letters of endorsement, issued from state agency colleagues and nonprofit stakeholders, representing both mental health and substance use treatment professionals and organizations. Three statewide trade associations (the Illinois Alcoholism and Drug Dependence Association, Illinois Association of Rehabilitation Facilities and Community Behavioral Health Association) in addition to the state agency designated team members and Illinois' two Regional Extension Centers formed part of the steering committee for the project. With all the right people at the table, the team targeted mental health and substance use treatment providers to engage in Illinois Behavioral Health Integration Project (BHIP).

In its original design, BHIP sought to ensure that behavioral health providers were ready to adopt EHR systems, were able to exchange health information electronically and that the ILHIE understood what policy and programs would be necessary in order host behavioral health providers on the system and foster real time electronic data sharing of behavioral health data.

Over the course of implementing BHIP, we have compiled a complex understanding of providers and consumers involved in the behavioral healthcare system. We connected with over 384 unduplicated behavioral health organizations throughout Illinois and registered 81unduplicated behavioral health organizations and 352 staff members on ILHIE Direct.

Project initiatives fostered an aggressive outreach strategy that sought the engagement of behavioral health providers and consumers in shaping policies governing the integration of behavioral health data in the HIE and testing the electronic exchange of patient information. In particular, BHIP hosted two statewide meetings to launch the project and to share project results in the end. It conducted both provider and consumer focus groups, as well as fund six demonstration projects for electronic exchange. It identified three use cases for dissemination. BHIP introduced a tool kit for patient consent to provide a baseline of tools and information for providers to use in exchange. These activities laid the groundwork to modernizing the Illinois Mental Health and Developmental Disabilities Confidentiality Act.

Modernizing the Illinois Mental Health and Developmental Disabilities Confidentiality Act

Through the identification and sustained dialogue with this cohort of providers and stakeholders, Illinois led a successful state legislative initiative to modernize the Illinois Mental Health and Developmental Disabilities Confidentiality Act. In its original form, the Act reflected the restrictive nature of the patient consent provisions of the federal regulations (42 CFR Part 2) governing the administration of substance use information at specified treatment facilities and units. Patient consent under the Act required a designated recipient, specified information that was being transmitted, an expiration date for that information, patient signature and a witness. Further, the Act also required an audit trail and prohibited advanced and blanket consent, as well as governed all records no matter the location or the origin.

The Illinois legislature passed the new legislation[22] in May 2013 and the Governor signed it in August. This new Act now provides individuals receiving mental health treatment with an opt-out consent choice to share their health information via the HIE. This choice must be offered in a way that supports a meaningful decisions such that patients understand the implications of their decision and related remedies of the decision. The new Act provides for revocation of an existing choice. However, only providers connected to the HIE can offer their patients opt-out. If patients opt-out or are not affiliated with providers connected to the HIE, they can still have their information shared via fax or U.S. Mail. In addition, it allows for the sharing of this health information for care coordination and interagency coordination purposes without consent.

This legislation was supported by ten endorsing entities which included notably: Illinois Psychiatric Society, National Association of Social Workers – Illinois Chapter among others. While the legislation was considered in the Illinois Senate, both the Illinois Association of Psychologists and members of NAMI endorsed the legislation.

Nationally, 1 in 4 individuals have been treated for at least one diagnosis of mental health. This and the increasing role of physicians in the diagnosis and treatment of mental health has made it critical that mental health information is made available in its entirety to the HIE, pending patient authorization. Modernizing the mental health confidentiality act in Illinois ensures that HIE can fulfill a critical role in ensuring access to appropriate care for individuals with mental health disorders and facilitates greater likelihood of receiving better care now that the information can be shared.

[22] Illinois Public Act 098 - 0378

Illinois Policy Framework for HIE & Care Coordination

Illinois built a strong policy foundation to reform its state Medicaid program and address the mental health service needs of its recipients, starting in 2009 and in the run-up to applying for the SAMHSA-HRSA national demonstration project for CIHS-HIE. Among the state policy changes that Illinois secured in the wake of the Affordable Care Act and the American Recovery Act, Illinois authorized the creation of the Illinois Health Information Exchange (ILHIE); it defined insurance coverage parity for individuals with mental health diagnoses, and began the process towards Medicaid reform, addressing care coordination among medical and behavioral health providers and performance fee structures.

Illinois was one of twelve states eligible for the CIHS-HIE program primarily because of its commitment to including the behavioral healthcare community in the planning and development of the ILHIE, which was in its second year of development by the time National Council awarded the grant. The ILHIE's authorizing act, passed in 2010, required the inclusion of behavioral health in both the administration of the exchange and among the stakeholders serving on its Advisory Committee for its statewide health information exchange entity, the Illinois Health Information Exchange (ILHIE). Illinois also enacted historic Medicaid reform legislation in 2010, which specified that services would be provided in a "coordinated care" setting, involving behavioral health care and that health care services could be delivered via electronic health records.

Illinois awarded its first Medicaid care coordination contracts in 2010 for Seniors and Persons with Disabilities in the suburbs of Chicago. A second RFP for provider-driven care coordination networks across the state was issued in 2012. At the end of 2012, HFS selected six provider networks, called Care Coordination Entities. Behavioral health is a central component of these entities.

In 2011, Illinois Governor Pat Quinn signed into effect the Mental Health and Addiction Equity Act, requiring health insurance plans, including those for employers with 2 – 50 employees, to cover mental health and addiction services on par with medical services.

Despite the promising advancements in the policy framework to support care integration, Illinois has struggled with one of the nation's most severe revenue shortfalls since the economic downturn. While the State enacted a two percentage point increase in its personal and corporate income taxes in 2011, it simultaneously has had to reduce spending and roll back its commitments especially in Medicaid, as well as mental health.

Medicaid reduced its patient roles by 1.7 million by lowering the eligibility threshold to 133% of Federal Poverty in anticipation of both the new eligible individuals joining the patient load in 2014 and the health insurance exchange covering all those above 133% starting that year as well. Medicaid also experienced a concomitant budget reduction of $1.6 billion. Some estimate that mental health funding has declined by 30% since 2008.

When Illinois received the funding to participate as one of five states in the national demonstration project for the CIHS-HIE in January 2012, it was embarking on project that would engage with providers and consumers long familiar with very stringent practice areas and silos of care in mental health and substance use services. The successful modernization of the Illinois Mental Health and Developmental Disabilities Confidentiality Act opened up the opportunity for electronic data sharing, clarified the terms of this exchange and supported the advent of the ILHIE and care coordination.

Conclusion

If the goal of care coordination and integration is sharing a consolidated electronic health record that incorporates medical and behavioral health information, then this is not yet available nationally. Despite this, there is movement away from the current model and its request for specific data towards cross specialty consultation on various kinds of patient information among behavioral health providers and their medical counterparts.

The Illinois experience demonstrates how through state policy prerogatives, federal policy changes and provider adaptation that there has begun a significant shift away from siloed care and towards care coordination and in at least one documented case, care integration. Behavioral health providers are at the center of these changes, moving forward on evolving the existing model. They have been able to integrate EHR systems, meet meaningful use measures, and become eligible for incentive funding. The core measures of meaningful use that they are meeting form the basis of basic EHR capabilities.

Transitioning out of paper-based processes, especially replacing fax transmission with electronic exchange, for example ILHIE Direct, requires extensive reworking of staff roles, responsibilities and work flow. Process re-engineering to accommodate ILHIE Direct does deliver significant efficiencies and can open up options to either treat more consumers or add new services. The implementation of ILHIE Direct in some circumstances improves the existing care setting, it also has been shown to lay the ground work for changing the model and bringing behavioral and medical providers into one consulting team.

The progress that has been made in large part reflects the interest and desire of behavioral health providers and consumers seeking new ways of solving an old problem, the problem of access to care when it is needed, often in an environment of uncertainty and increasing fiscal change and austerity. By demonstrating that behavioral health providers can exchange patient health data electronically, supporting a “warm hand-off” to relevant services in a minimal amount of time, it is clear that solutions to this old problem do exist.

There is still much innovation expected in the field of health information exchange and the integration of behavioral health data. In particular, the national effort to create a behavioral health continuity of care document holds much promise for ensuring that appropriate and relevant behavioral health information can be included as an extension to an existing electronic record – ultimately producing that holy grail of integration – a consolidated medical and behavioral health record. Equally, efforts that seek to support patient preferences in data sharing, especially for individuals who have sensitive health information to protect, such as those that are based on standardizing heath information can ensure greater reliability of the data in transmission.

To further behavioral health integration in the HIE as well as in care coordination, behavioral health providers must be supported in their efforts to meet all meaningful use measures. Drawing on the experiences of providers that have been successful in doing so and compiling relevant easy to use tools could help to accelerate this process. Additionally, the work on the national level to seek parity for behavioral health providers in the incentive programs is also important.

Another area that will be fruitful to research is how substance use treatment facilities and programs are addressing care coordination, electronic health records and HIE. While the qualitative research in Illinois conducted in 2012 reflected participation by a portion of these providers, their participation was lowest for

providers of any behavioral health category. And, as results have shown, they are the least likely to invest in an EHR system. They are governed by a restrictive patient consent law and it will be interesting to see whether this law or any aspect of it will be modernized to support HIE usage. While both substance abuse treatment providers and patients are a relatively small group in health care, they provide a critical, yet costly service, to improve overall health and wellness.