

# **BHI COLLABORATIVE** **PRESENTS**

OVERCOMING OBSTACLES WEBINAR SERIES

**Sustaining behavioral  
health care in your practice**

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January 27, 2021

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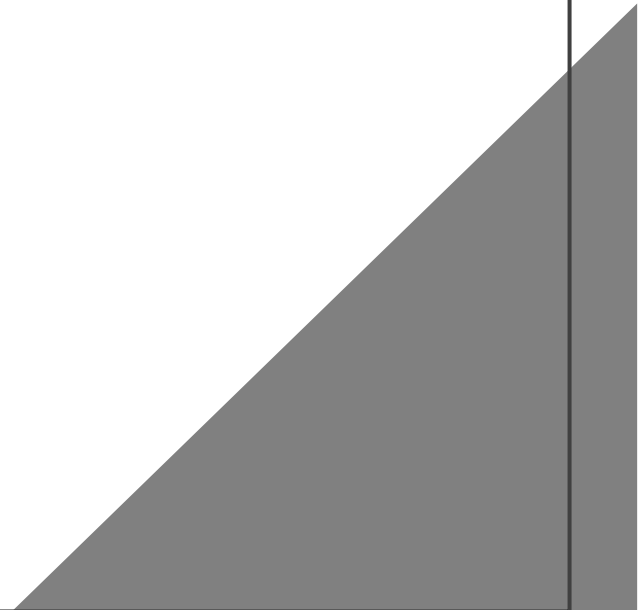
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# Overcoming Obstacles Webinar Series

*This series is focused on enabling physicians to sustain a collaborative, integrated, whole-person, and equitable approach to physical and behavioral health care in their practices during the COVID-19 pandemic and beyond.*



# About the BHI Collaborative

*The BHI Collaborative was established by several of the nation's leading physician organizations\*\* to catalyze effective and sustainable integration of behavioral and mental health care into physician practices.*

*With an initial focus on primary care, the Collaborative is committed to ensuring a professionally satisfying, sustainable physician practice experience and will act as a trusted partner to help them overcome the obstacles that stand in the way of meeting their patients' mental and behavioral health needs.*

*\*\*American Academy of Child & Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Medical Association, American Osteopathic Association, and the American Psychiatric Association.*

# **TODAY'S TOPIC:**

***Privacy and Security:  
Know the Rules for Communication  
of Behavioral Health Information***

# TODAY'S SPEAKERS



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Robin M. Motter-Mast, DO, CPE  
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GBMC Healthcare



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VP/Chief Medical Officer  
and Chief Medical  
Information Officer  
Sheppard Pratt



# Privacy and Security: Know the Rules for Communication of Behavioral Health Information

For the BHI Collaborative

January 27, 2021

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UNH Franklin Pierce School of Law

College of Health and Human Services

Institute for Health Policy and Practice

# Goals for Today

1

Address mythical barriers and pathways

2

What standards apply and changes are underway?

3

What matters to practitioners providing integrated behavioral health?



# Coordinating Care Between Clinically Integrated Providers

The goal of the recent regulatory frameworks at the federal level is to balance patient privacy against the needs for information sharing as part of the collaborative health care system.

# The Many Laws Regulating Privacy and Confidentiality Laws

Jurisdiction	Statute or Regulation	Scope
<b>Federal</b>	<b>HIPAA Privacy and Security Rules</b>	Protects individually identifiable private health information (PHI) maintained by providers, payers and their contractors from disclosure. Heightened protections for psychotherapy notes.
	<b>42 CFR Part 2</b>	Protects the confidentiality of “substance abuse” patient records from disclosure without express patient consent.
	<b>FERPA</b>	Protects education records
<b>State Laws</b>	<b>Privacy of medical records</b>	E.g., Medical information in the medical records in the possession of any health care provider shall be deemed to be the property of the patient
	<b>Special rules for minors</b>	E.g., Protects reports and records of treatment of minors for drug dependency as confidential
	<b>Privacy of mental health records</b>	E.g., Protects communications between mental health practitioners and patients as privileged
	<b>Privacy of substance use treatment records</b>	E.g., Protects information held by a licensed alcohol or other drug use professional performing substance use counseling services.
	<b>Special rules for patients in acute distress</b>	E.g., Regulates disclosure of information amongst providers in the event of a mental health emergency or involuntary admission.

# HIPAA and HHS Developments

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**“Right of Access”** initiative announced in 2019



December 10, 2020 (OCR): **Proposed Privacy Rule** following RFI in 2018 enhancing ability to share information for care coordination and care management



**Interoperability and Information Blocking Rule** (eff. April 5, 2021) - requires health care providers to give patients access to their ePHI.



**Final Rules Anti-Kickback Statute and Stark Laws** (effective January 19, 2021) – enhance alternative payment models



# As a HIPAA Provider...

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- Physicians may disclose Protected Health Information (PHI) (whether orally, on paper, **by** fax or electronically) for ***treatment, payment and health care operations*** without consent or authorization.
- HIPAA treats mental health information the same as other information
- Health care providers may disclose to other health providers any PHI contained in the medical record about an individual for treatment, case management, and coordination of care.
  - *except that* covered entities must obtain individuals' authorization to disclose separately maintained psychotherapy session notes for such purposes



# As a HIPAA Provider – Substance Use

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- Physicians can share health information with family and close friends who are involved in care of the patient if the provider determines that doing so is in the best interests of an incapacitated or unconscious patient and the information shared is directly related to the family or friend's involvement in the patient's health care or payment of care.
- *For example, a provider may use professional judgment to talk to the parents of someone incapacitated by an opioid overdose about the overdose and related medical information, but generally could not share medical information unrelated to the overdose without permission.*

# HIPAA

HHS

**Applies to** covered entities (healthcare providers, health plans, healthcare clearinghouses) and Business Associates

**Protects:** privacy and security of general health information

**Purpose:** to protect health data integrity, confidentiality, and accessibility

**Permits** disclosures *without* patient consent for treatment, payment and healthcare operations and for public health purposes.

# 42 CFR Part 2

SAMHSA

**Applies to** SUD patient records from federally-assisted “Part 2 programs”

**Protects:** privacy and security of records identifying individual as seeking/receiving Substance Use Disorder (SUD) treatment

**Purpose:** to encourage people to seek Substance Use Disorder (SUD) treatment and reduce stigma through enhanced confidentiality

**Prohibits disclosures *except with*** a patient consent for treatment, payment, and healthcare operations, with limited exceptions

## SUD Services

# *Are You Or Your Practice a “Part 2 Program”?*

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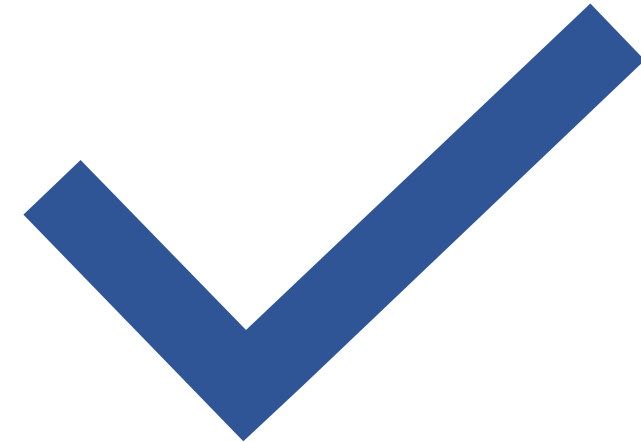
- An individual or entity (or a unit in a general medical care facility) that holds itself out as providing **and** does provide SUD treatment, diagnosis or referral for treatment? **or**
- Staff in a general medical facility whose primary function is the provision of SUD services and who are identified as a SUD providers? **and**
- Is federally “assisted” (with the exception of some Veterans’ Administration services).



# Part 2 Requirements – Check List

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- I. Patient Records Security policies that meet the new Part 2 standards
- II. Notice of privacy rights that meet Part 2 requirements
- II. Compliant consent forms
- III. Non re-disclosure notices when Part 2 information disclosed with consent
- IV. Qualified Service Organization Agreements when necessary





# Questions

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Do all primary care providers who prescribe controlled substances to treat substance use disorders meet the definition of a “program” under Part 2?

- ☐ Yes
- ☐ No

Is information generated by the provision of SBIRT (Screening, Brief Intervention and Referral to Treatment) services covered by Part 2?

- ☐ Yes
- ☐ No
- ☐ It Depends

# COVID Emergency - Telehealth

## HIPAA

- [OCR announced](#) it will waive potential penalties for HIPAA violations arising out of *good-faith use of telehealth*
- Providers may use popular video chats, like FaceTime, Messenger, Google Hangouts, Zoom, or Skype
- Providers do not need to have a BAA in place
- *Does not matter whether telehealth service is directly related to COVID-19*

## 42 CFR Part 2

- [SAMHSA's COVID-19 Part 2 Guidance](#) emphasizes that providers have discretion to determine whether *bona fide* medical emergency exists
- COVID-19 may present an emergency preventing a patient from accessing SUD services without telehealth

# Guidance For Integrated Practices

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- Privacy rules are drafted to encourage information sharing to support care management and care coordination.
- HIPAA allows for the sharing of information for Treatment, Payment and Health Care Operations.
- Treatment records created by a primary care physician (not a Part 2 provider) based on her own patient encounters are explicitly **not** covered by Part 2 under the new rules – even if she occasionally Rx's medically assisted treatment for a primary care patient with a SUD.
- Integrated behavioral health teams may share treatment information about their patients and disclose information for administrative purposes
- Electronic Health Records are being pressed to be able to accommodate special protections.
- But remember, substance use disorder stigma is real!

# Work with Your Team

Think about your patient flow

What do you want to be able to share?

With whom?

When?

Why?

Create pathways to support integrated care.

# Thank you

[Lucy.Hodder@unh.edu](mailto:Lucy.Hodder@unh.edu)

# **Integrating Behavioral Health into Primary Care: Successes & Challenges**

**Robin Motter-Mast, DO, CPE**  
Chief of Staff and Medical Director of Care  
Transformation  
*Greater Baltimore Medical Center*

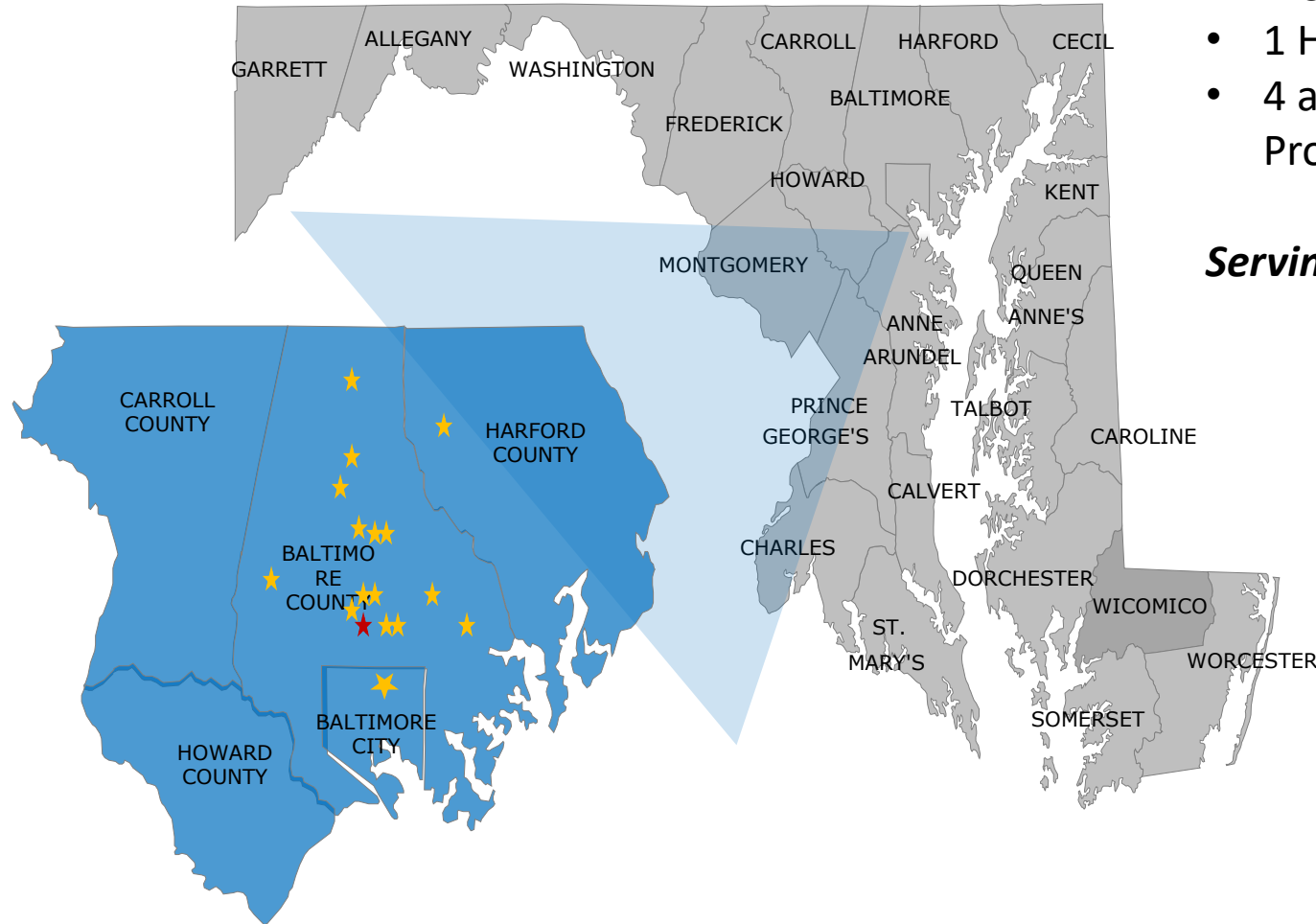
**Todd Peters, MD**  
VP/Chief Medical Officer and Chief Medical  
Information Officer  
*Sheppard Pratt*

# Integrated Care: *Model and Process*



*"To every patient, every time,  
we will provide the care that we  
would want for our loved ones"*

# GBMC HealthCare System



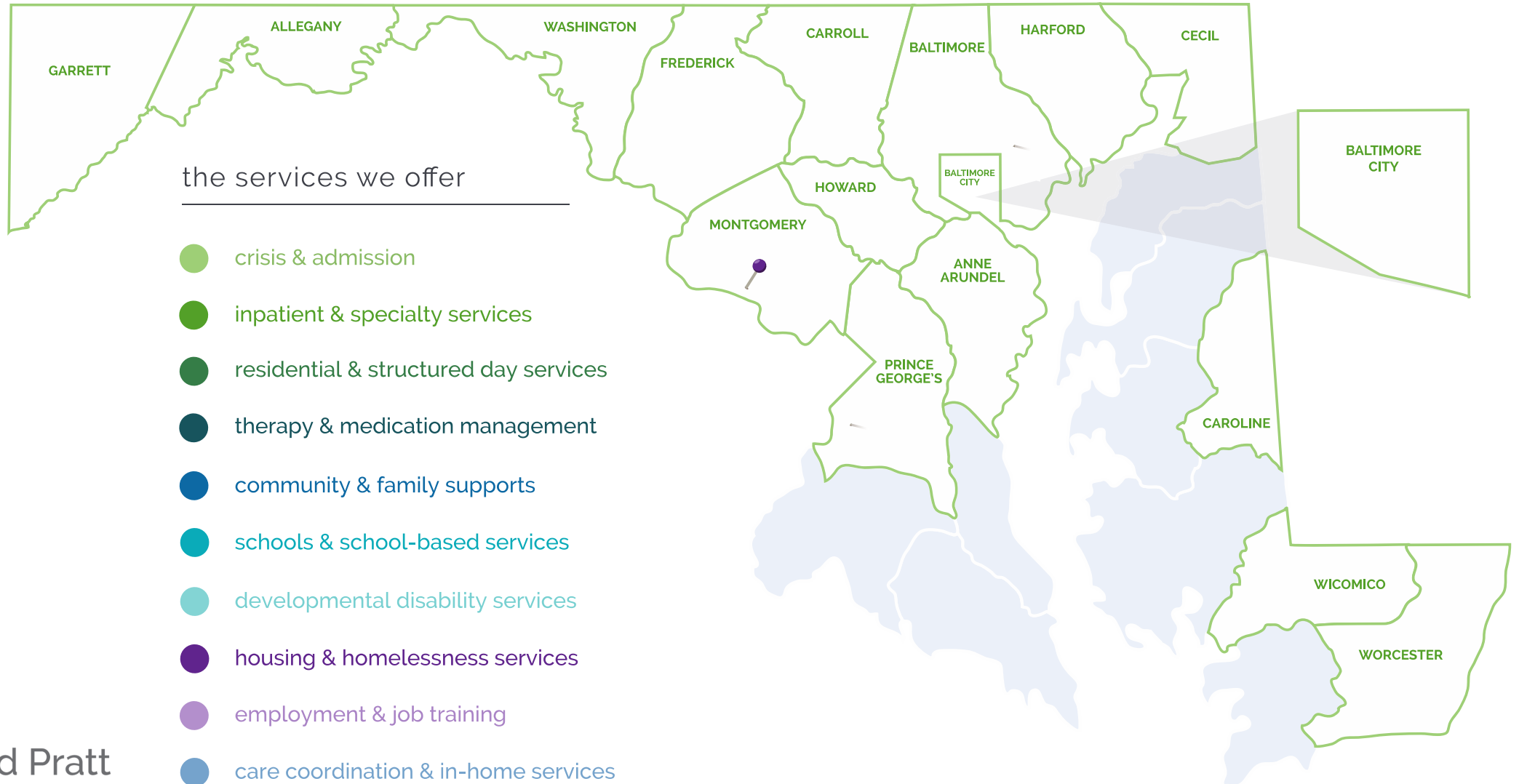
Integrated services in:

- 12 Primary Care Practices
- 1 Complex Care Clinic (HU)
- 1 Homebound Patient Practice
- 4 aligned Maryland Primary Care Program independent practices

***Serving approximately 80,000 lives***



# Creating Access to Excellence





# Sheppard Pratt's Impact to the Community

## Mission Statement

To improve the quality of life of individuals and families by compassionately serving their mental health, addiction, special education, and community support needs.

**#1** private, nonprofit  
provider of  
**PSYCHIATRIC  
SERVICES**  
in the nation



More than  
**380**  
**SITES OF  
SERVICE**



Serving patients from  
**41 STATES &  
21 COUNTRIES**



**LARGEST  
PROVIDER**  
of nonpublic **special education**  
programming in Maryland



**RANKED 5th**  
in the nation of psychiatric hospitals  
by *U.S. News & World Report*



More than  
**160** PROGRAMS  
across  
**16 MARYLAND  
COUNTIES**

# Creating Access to Patient-Centered Care

## crisis & admission

- crisis walk-in clinic
- assessment and intake services
- therapy referral services

## inpatient & specialty services

- child, adolescent, adult, geriatric services
- intellectual disabilities, trauma, neuropsychiatry, eating disorders, sports

## residential & structured day services

- day hospitals
- crisis residential services
- psychiatric rehabilitation services
- residential treatment services

## therapy & medication management

- addiction services
- outpatient behavioral health services
- integrated primary and behavioral health care services
- telepsychiatry services

## community & family supports

- head start program
- domestic violence shelter
- early intervention parenting support

## schools & school-based services

- nonpublic special education
- school-based mental health services
- residential treatment centers

## developmental disability services

- neuropsychiatry services
- intellectual disabilities and autism unit
- schools and school-based programs

## housing & homelessness services

- homeless outreach services
- housing counselor services
- veterans service center

## employment & job training

- business services
- employment support
- vocational services

## care coordination & in-home services

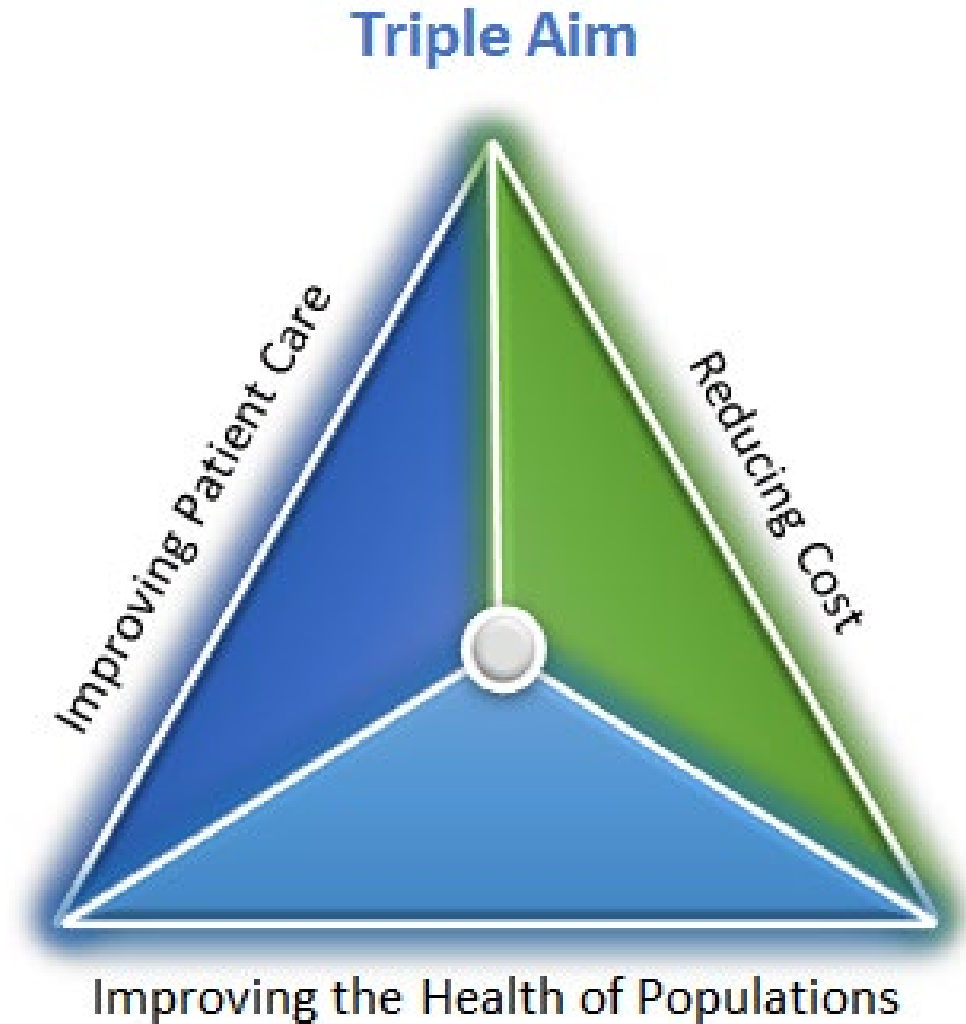
- assertive community treatment services
- behavioral health home services

# Impact on Total Cost of Care

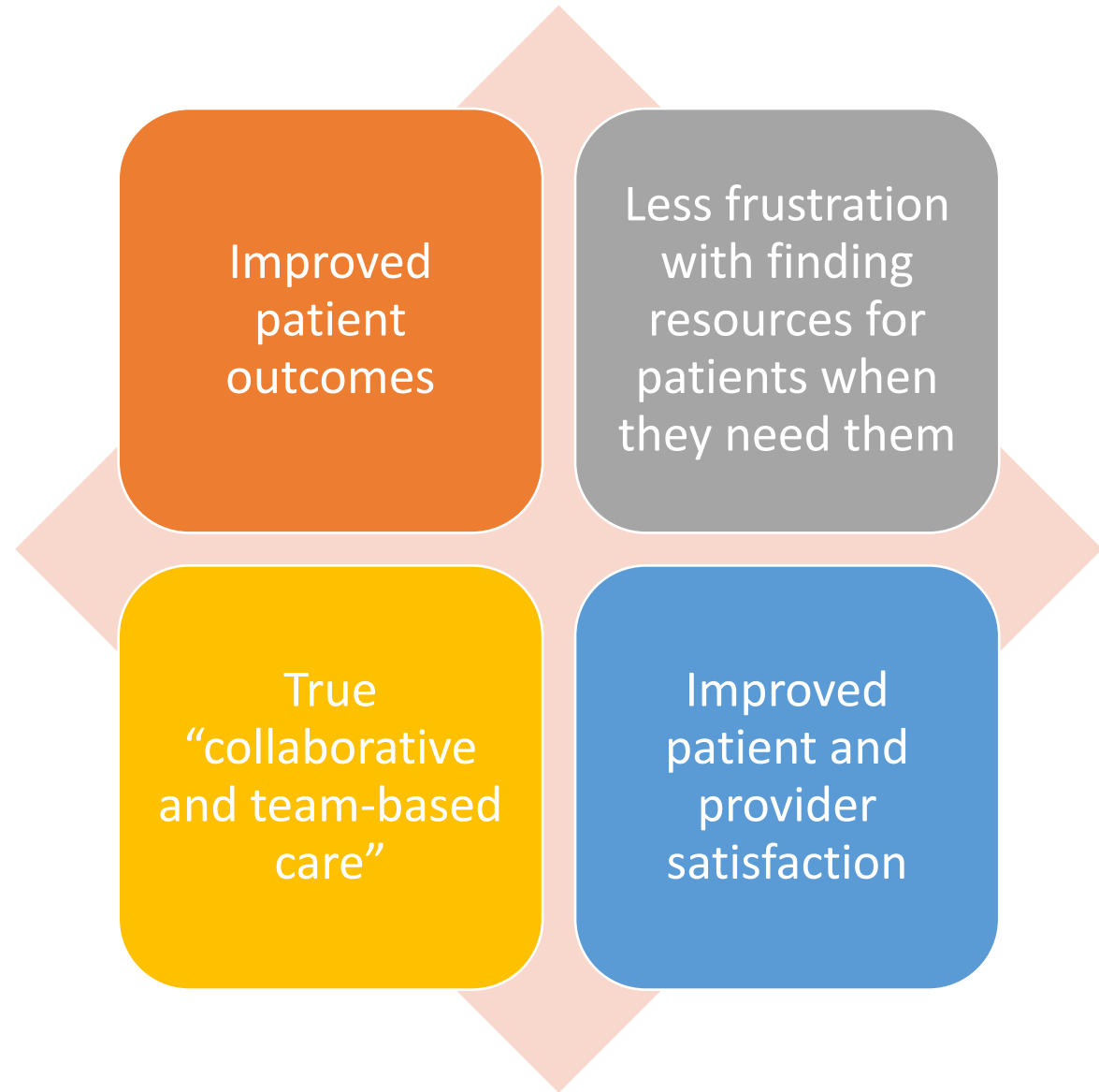


# Key Points

- Mental illness and substance use (**behavioral health problems**) are major drivers of health care **utilization** and **cost**
- Effective treatments exist, but currently **no more than 25%** of people in need receive indicated care
- Not enough specialty/mental health providers to address this gap
- **EFFECTIVE *INTEGRATION*** of behavioral health care with primary care can achieve:
  - Better **access** to care
  - Better health **outcomes**
  - Lower **costs**



# Benefits to Behavioral Health Integration



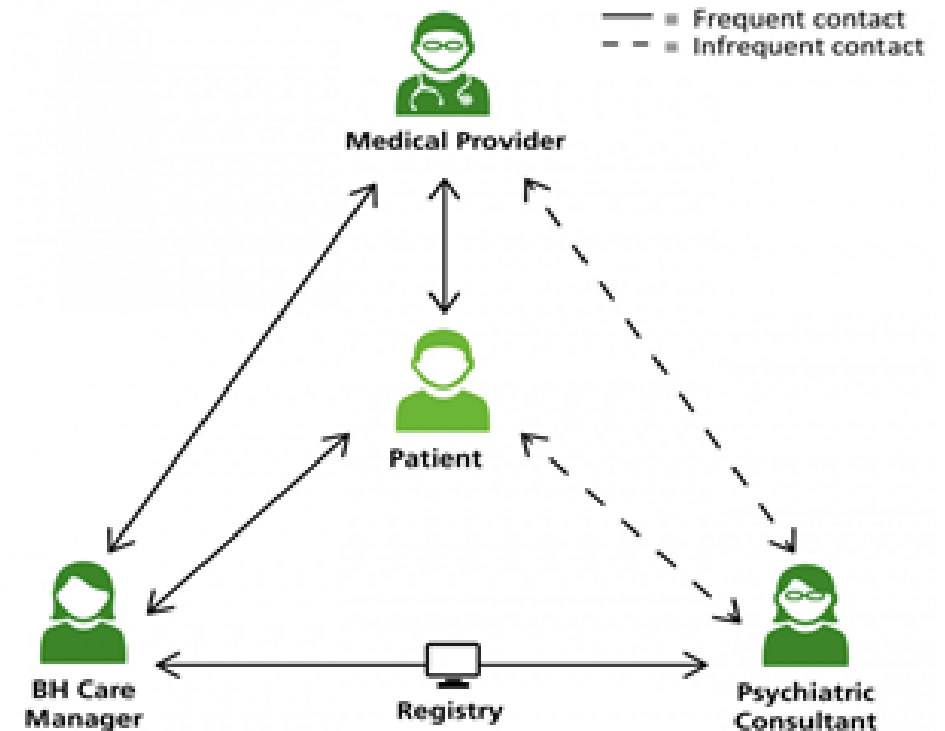
# The Collaborative Care Team

**Patient** – The patient is the most important member of the care team

**Treating (Billing) Practitioner** – A physician and/or non-physician practitioner (PA, NP, CNS, CNM); typically primary care, but may be of another specialty (e.g., cardiology, oncology)

**Behavioral Health Care Manager (BHCM)** – A designated individual with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight and direction of the billing practitioner

**Psychiatrist Consultant** – A medical professional trained in psychiatry and qualified to prescribe the full range of medications



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## Business and Clinical Case

Medical Costs per Disease State					
Chronic Medical Condition	PMPM With Behavioral Condition	PMPM Without Behavioral Condition	% Treated For Depression or Anxiety	Expected Depression or Anxiety Prevalence	% Missed
Arthritis	\$871.88	\$564.76	7.1%	32.3%	77.9%
Asthma	\$861.99	\$470.05	6.8%	60.5%	88.8%
Cancer (Malignant)	\$1,180.96	\$1,018.45	5.7%	39.8%	85.7%
Chronic Pain	\$1,210.56	\$884.70	5.9%	61.2%	90.4%
Coronary Artery	\$1,305.00	\$958.34	5.7%	48.2%	88.1%
Diabetes	\$1,110	\$828.18	5.2%	30.8%	83.2%
Heart Failure	\$2,242.85	\$1,888.11	7.0%	43.8%	84.1%
Hypertension	\$880.33	\$588.04	5.5%	30.5%	82.0%
Ischemic Stroke	\$1,461.57	\$1,254.68	7.7%	52.4%	85.2%

Cost Burdens from unrecognized/undiagnosed/Mental Health Cases.



# COLLABORATIVE CARE MODEL BILLING



## Time-based bundled codes:

Captures all direct and indirect care provided by care manager and psychiatrist,

Billed by the PCP

Initial (first month), subsequent months, and additional time codes can be used as long as service delivered (no duration limits)



## Requirements include

Can be used for any BH condition  
Use of Validated rating scales (every month)

Use of a registry to facilitate weekly case review

Presence of BH care team: PCP, BH care manager, psychiatric consultant

BH care manager NOT required to deliver care on-site





## Documentation for billing

Accounting for time spent (similar to CCM)

Evidence of core components of care elements (through reports, notes etc)



# Consent

- ***No separate consent needed***, only the providers annual consent to treat agreement
  - Consent needed for participation in model for ***billing purposes only***
    - Documented during a visit
    - Verbal (over the phone)
    - Patient Portal
- 
- 



## Improved communication on patients mental and substance abuse issues

- Located in the medical record for other providers (only) to see across the hospital system
  - Certain types of notes are protected from ALL staff view
- Substance Abuse issues are not available for ALL to see, but referrals and notes on appointments can be seen
  - Hand-offs between the ER and the Epic system's primary care providers on peer-to-peer recovery program participation
- Care Team alerts are placed in the state HIE when appropriate

# Barriers

- Working with lawyers can be hard, difficult to move from past ideas on privacy, ***but can be done!***
- Decisions on “break the glass” versus “sensitive” information in EMR
- Landscape is changing-CURES Act, coming soon
- What to do with patients that don’t fit “the model”
- Marketing the model to the community
- Most insurance carriers are covering codes (not Medicaid)



# Insurance Coverage

- All major payors processing bills
- No substantive denials
- 968 claims submitted between June and October

AETNA

ALTERNATE UHC SHARED SERVICES

CAREFIRST

CAREFIRST ADMINISTRATOR

CAREFIRST BLUE CHOICE HMO

CIGNA

CIGNA HMO

JOHNS HOPKINS

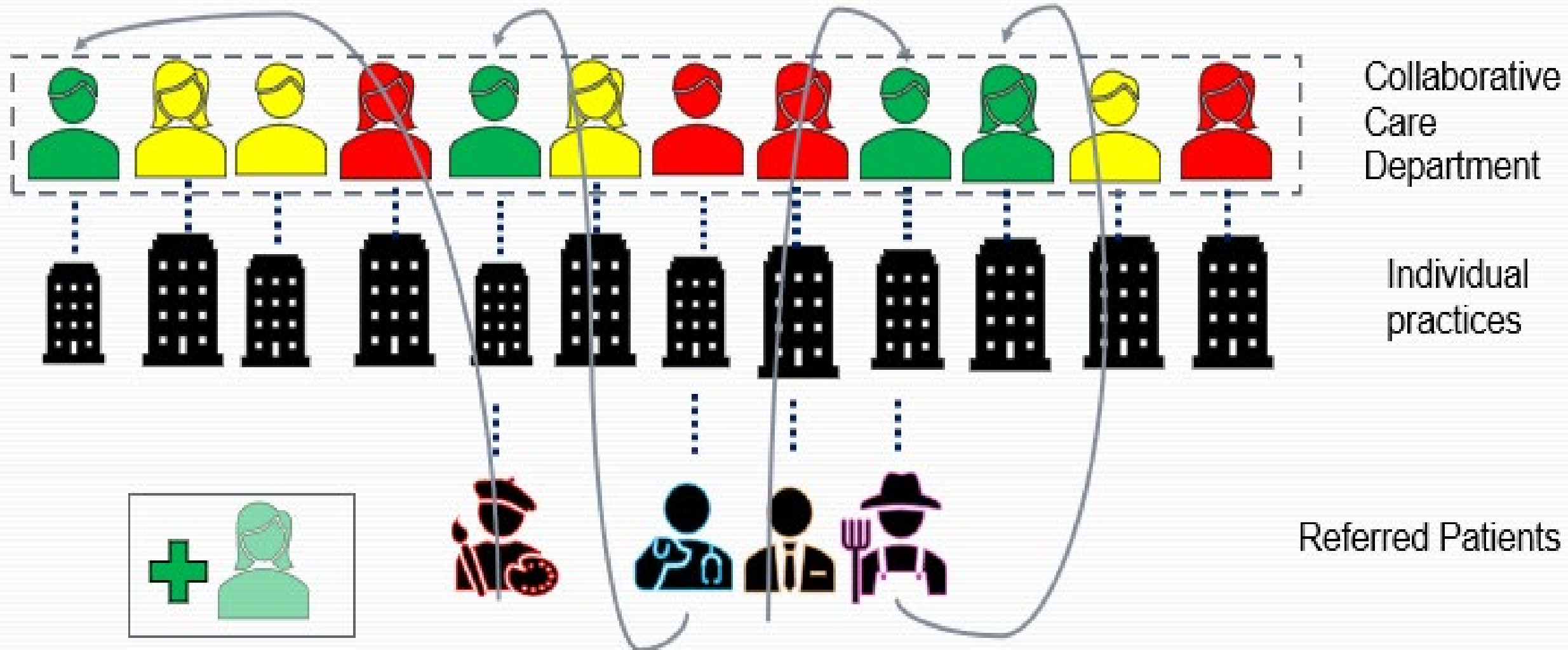
MEDICARE

TRICARE

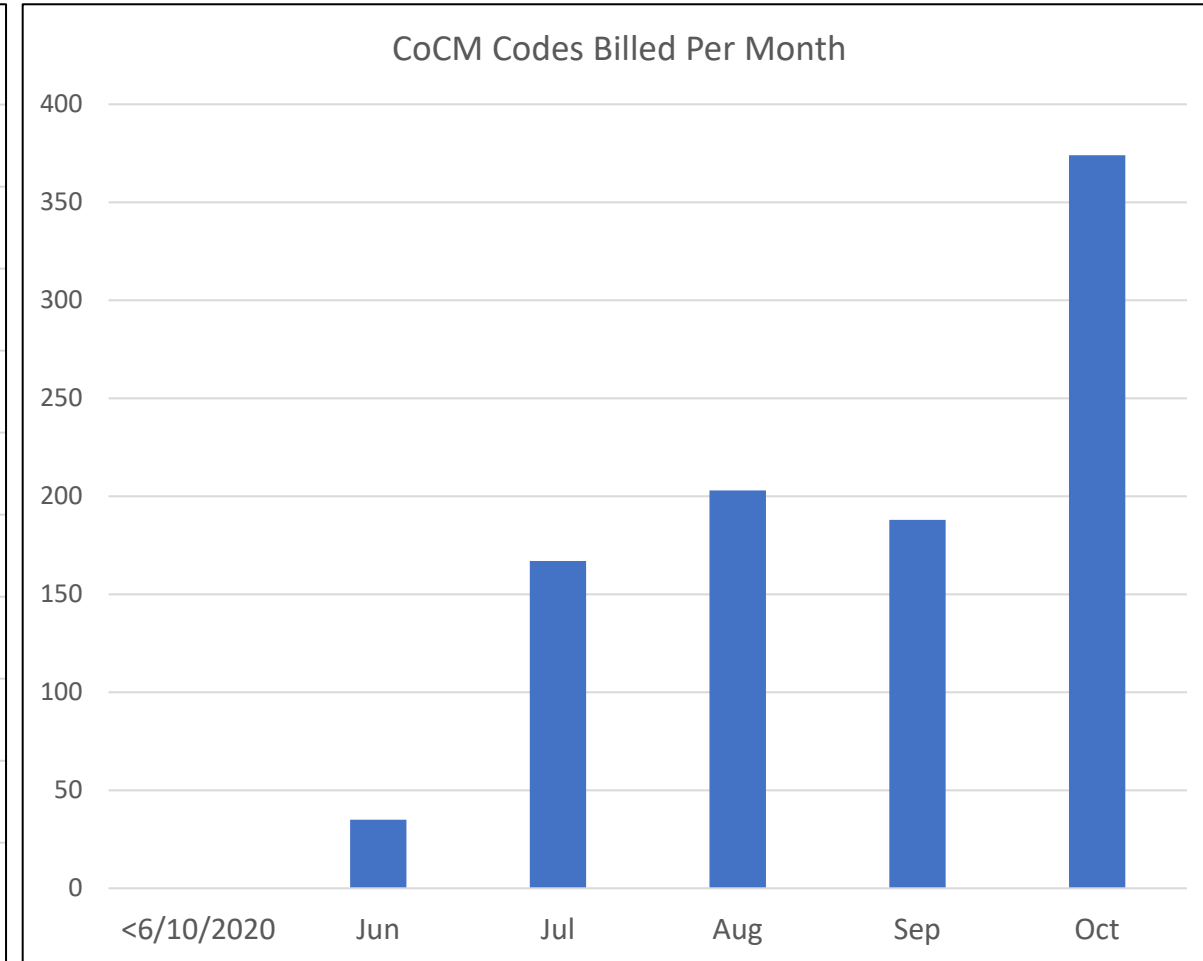
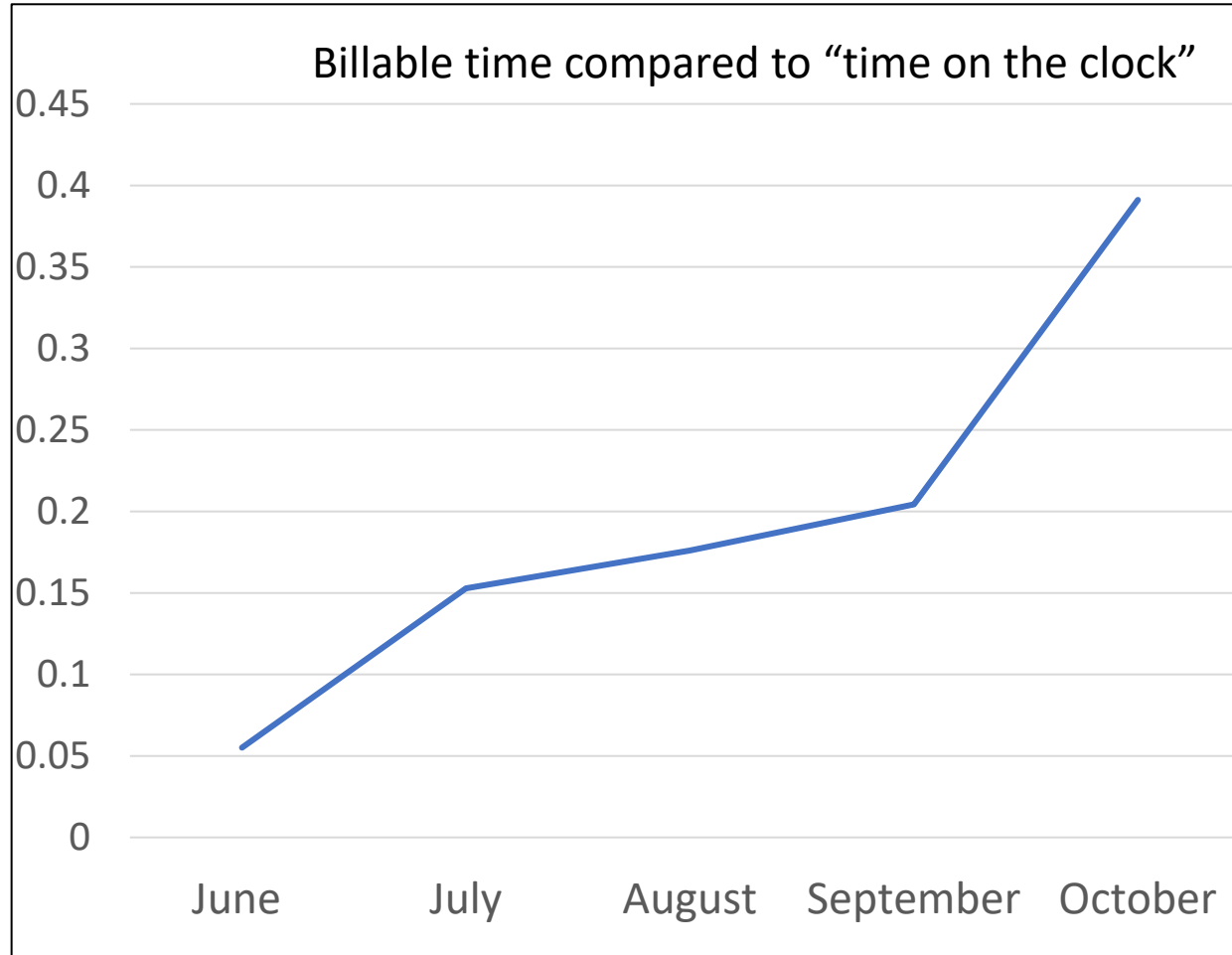
TRUSTMARK HEALTH BENEFITS

UNITED HEALTHCARE

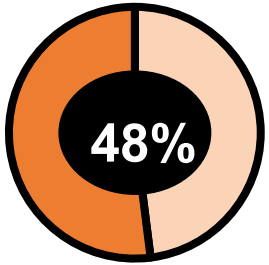
# Universal Work Queue Approach



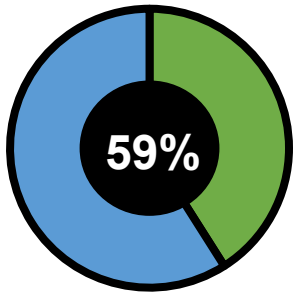
# Productivity Since Launch



# CoCM Patient Progress

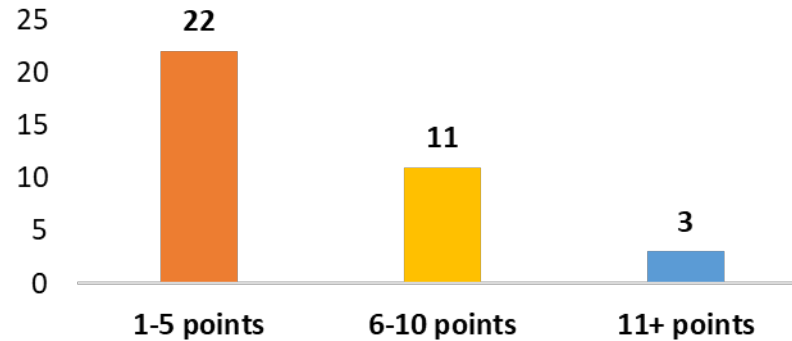


have maintained or  
reduced PHQ-9 Score



have maintained or  
reduced GAD-7  
Score

## Magnitude of PHQ-9 Reduction



## Patient Success Stories

How likely are you to recommend the program?

**93%**  
(7% neutral)

If the program was not available through your PC office, how likely is it that you would have seen a therapist elsewhere?

**39%**

Please rate your overall experience  
(1-5) with the program

**4.7**

*"Thanks so much for your continued support of my anxiety condition. I'm feeling a lot better and the collaborative care model has been great."*

*"I am so happy I joined the mental health program at the office. I've already told multiple friends what a positive experience this has been, and how the collaborative approach is so effective."*

*"Thank you for being there when I needed so much support."*

*[BHCM] is amazing. She "got" me so early on in my therapy. She has continued to "read" me and offered compassionate, constructive suggestions for me to work on. I was in therapy for 6-8 years prior, and she is the best professional I have seen.*



# What do the people doing the work say...

## Behavior Health Care Managers

Like the increased access to psychiatry and overall BH care.

Enjoy the integration with primary care team.  
“It’s the best of everything, especially when providing patient support”

## Provider Feedback

“This program has been a godsend to my patients. I have benefitted immensely from the psychiatrist and BHCM’s expertise, and my patients rave about them. We have prevented ER visits and waits to see psychiatry. You need to do whatever it takes to keep the program around!”

Statement	Percent agree/strongly agree
I have adequate knowledge about prescribing psychiatric medications for depression and anxiety diagnoses.	94%
My patients have benefited from the brief therapeutic interventions provided by the BHCM.	87.5%
Recommendations regarding the use of psychiatric medication were helpful	69%
There has been clear communication between the CoCM team (BHCM, consulting psychiatrist, patient and provider).	94%

# What can you implement today

Formulate	Formulate a relationship with a group offering CoCM or hire your own team
Check	Check with your state to see if they have any recommended programs or partners for behavior health integration
Participate in	Participate in the AIMS Financial Modeling Office Hours to find out more.



**QUESTIONS?**



OVERCOMING OBSTACLES WEBINAR SERIES

# Sustaining behavioral health care in your practice

## UPCOMING WEBINARS

**Behavioral Health Integration in Small Practices**

February 25, 2021 2-3pm ET



**Thank you for  
joining!**

# APPENDICES

# Lucy C. Hodder

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Director of Health Law and Policy  
Professor, UNH Franklin Pierce School of Law  
Institute for Health Policy and Practice  
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Lucy Hodder is the Director of Health Law and Policy Programs at the University of New Hampshire College of Health and Human Services, Institute for Health Policy and Practice, and Professor of Law at UNH Franklin Pierce School of Law. She developed and oversees the Certificate in Health Law and Policy program for law students and teaches a variety of health law courses. Lucy's research addresses the health care payment and delivery system reform, and her projects focus on developing strategies for sustainable and patient centered systems.

She has practiced law for over 30 years, most recently serving as Legal Counsel to New Hampshire Governor Maggie Hassan and her senior health care policy advisor, working with the Governor on initiatives to expand access to health, mental health and substance use disorder services for New Hampshire citizens. Lucy is an experienced New Hampshire health care and regulatory attorney. Previously a shareholder in the firm of Rath, Young and Pignatelli, P.C., and Chair of the firm's Healthcare Practice Group, Lucy assisted providers and businesses navigate the changing health care environment. Prior to private practice, Lucy served as an Assistant Attorney General in the New Hampshire Department of Justice and began her practice in the San Francisco offices of Brobeck, Phleger and Harrison.

## What Part 2 Program Records are Protected by 42 CFR Part 2?

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A **Part 2 patient** is any individual who has applied for or been given a diagnosis, treatment, or referral for treatment for a SUD *at a Part 2 program*.

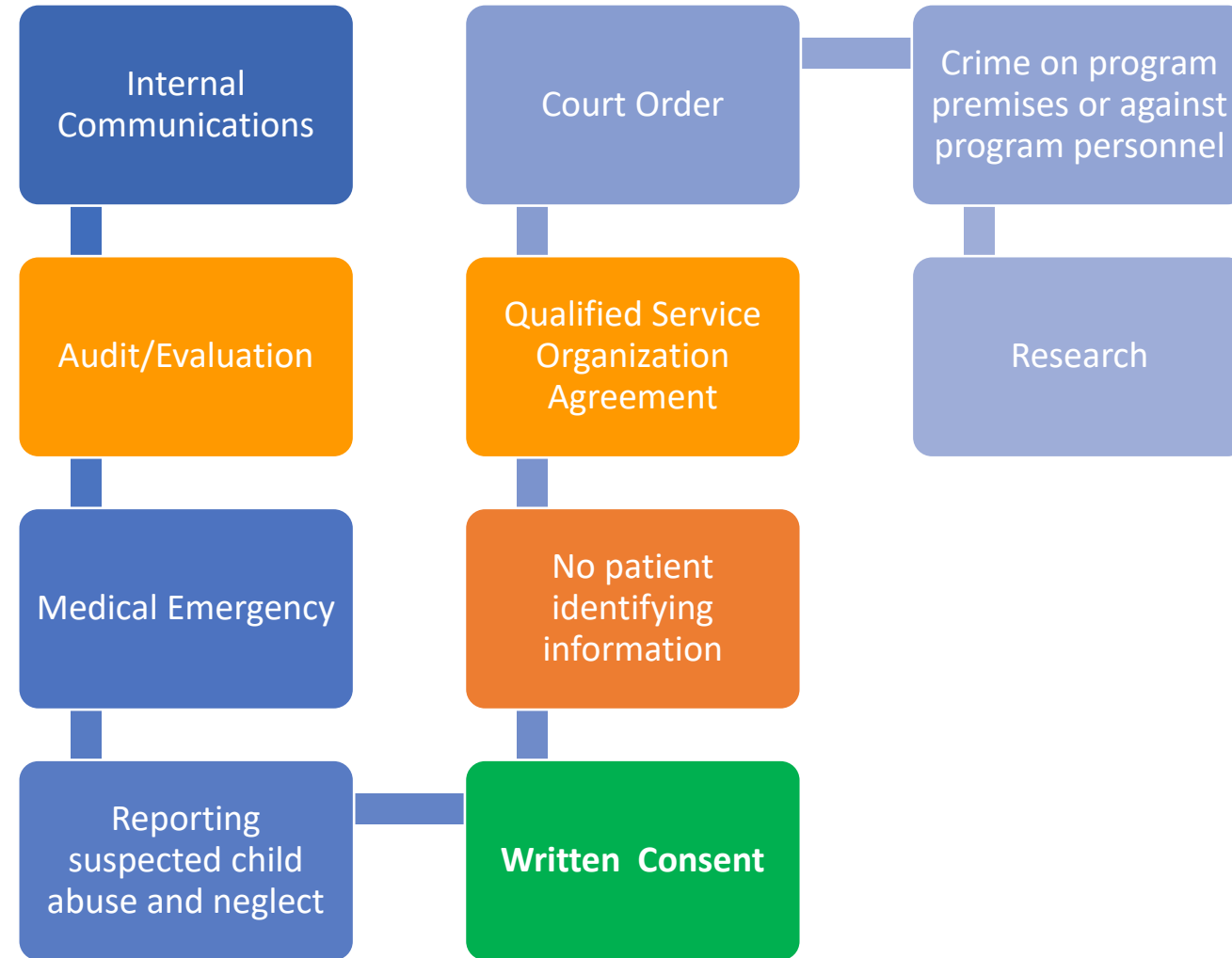
“**Treatment**” means the care of a patient suffering from a SUD, a condition which is identified as having been caused by the SUD, or both, in order to reduce or eliminate the adverse effects on the patient.

**Part 2 Protected Records** include:

- 1) Any information that *would identify* a patient as a SUD patient either directly or by verification;
- 2) Any information *about a patient* created, received or acquired by a Part 2 program for the purpose of treating alcohol or drug abuse, making a diagnosis for treatment, or making a referral for that treatment;

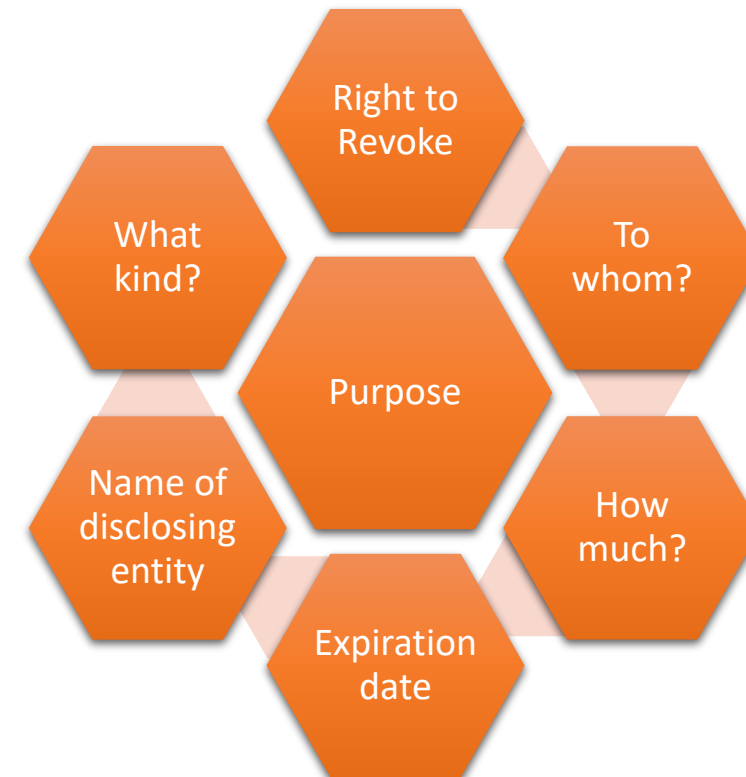


## When Can Part 2 Records be Shared?



# Patient Consent: Elements (2.31)

- 1) Name of the Patient
- 2) Names of Part 2 entities or providers making the disclosure
- 3) How much and what kind of information is to be disclosed including specific reference to SUD
- 4) “To Whom” is the disclosure being made?
- 5) The purpose of the disclosure
- 6) Right to revocation at any time going forward
- 7) The date, event or condition upon which the consent will expire.



# What Were the Key Changes to the Final Part 2 Rule?

Record 2.11	Applicability 2.12(d)(2)(ii)	Consents (2.31)	Consents for payment and health care operations	PDMP
Definition Change to Facilitate Care Coordination	Change to Facilitate Care Coordination	"To Whom" Simplified	Agents and administration made easier	Outpatient Treatment Providers
<p>Excludes information conveyed orally to a non-Part 2 provider for treatment purposes with a patient consent even if written down.</p> <p>Means resulting medical record is not covered by Part 2</p>	<p>A non-part 2 treating provider may "record information about a SUD and its treatment that identifies a patient." This is not a Part 2 record.</p> <p>Part 2 records received by the non-Part 2 treating provider should be segmented, however.</p>	<p><b>General requirement for designating recipients:</b></p> <p>Allows patients to name a <b>person</b> or <b>entity</b> to which a disclosure can be made</p> <p>Consent form no longer has to name a specific person at a non-treating entity.</p> <p>"to Housing Finance Authority"</p>	<p>A patient consent to another entity generally for "payment and health care operations" allows entity and agents to use Part 2 information as necessary for 18 different activities.</p> <p>Activities include "care coordination and/or case management services in support of payment or health care operations."</p>	<p>Part 2 Programs are permitted to enroll in a state prescription drug monitoring program (PDMP).</p> <p>Allows a treating provider to check a central registry to confirm the appropriateness of prescribed therapy.</p>
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## Care Coordination Between Providers

### New Definition of “Record” – oral communications

#### Telephone call from SUD provider

A Substance Use Treatment provider treating a health center patient calls with patient consent to alert the health center PCP to the patient's discharge from the treatment program. Health center staff writes note in primary care chart.

??

#### Are patient notes now Part 2 records?

NO! The record of the oral communication with consent does not become 'Part 2-protected' record merely because it's written down. Records otherwise transmitted by a Part 2 program to health center PCP are still protected by Part 2 but may be segregated to prevent the entire medical record from special protections.

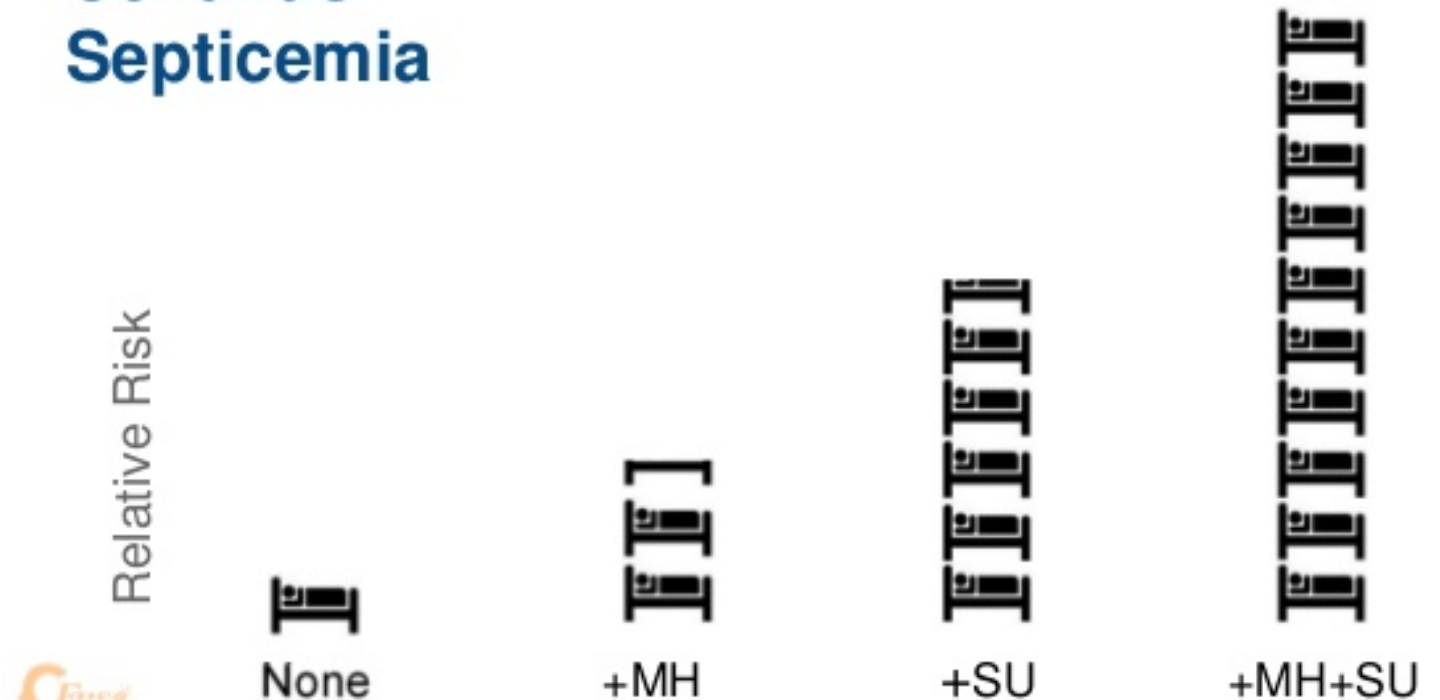
Rule change facilitates necessary communication about treatment between treating providers.

# Business and Clinical Case

Relative risk of medical admission with &  
without MH and SU comorbidity

-- Maryland Medicaid Adults, 2011

## Cellulitis Septicemia



Source: Hilltop Institute, 2012

ebg  
ADVISORS

EPSTEIN  
BECKER  
GREEN

thought leaders in  
**POPULATION HEALTH**  
Identifying implementation tactics



# Information Blocking and Open Notes

## Open Notes

Open Notes is invested in the Cures Act because clinical notes are among the information that must not be blocked—and thus be made available to patients.

### *What notes must be shared?*

The eight (8) types of clinical notes that must be shared are outlined in the United States Core Data for Interoperability (USCDI), and include:

#### USCDI:

- ✓ consultation notes
- ✓ discharge summary notes
- ✓ history & physical
- ✓ imaging narratives
- ✓ laboratory report narratives
- ✓ pathology report narratives
- ✓ procedure notes
- ✓ progress notes

### Clinical Notes Not Required to Share

**1. Psychotherapy notes** recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and ***that are separated from the rest of the individual's medical record***. Note: Clinicians and organizations are required to share medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

**2. Information** compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding.