



**Virna Little, PsyD, LCSW-r, SAP,
Senior VP for Psychosocial Services and Community Affairs
Institute for Family Health, New York, NY
vlittle@institute2000.org
May 13, 2011**

**Panel 1: Care Coordination Among Specialists, Primary Care, Care Management, Patients:
How can specialists leverage EHRs to fully participate in the continuum of patient care?**

1. How does your specialty or the specialties you work with handle the following?

Data exchange and referral loop

Behavioral health providers have not been included in the incentive programs for HIT, creating a barrier for the inclusion of mental health in the sharing of data and referral information. The large majority of mental health providers using electronic record systems are affiliated with healthcare systems. Most community mental health providers are either not utilizing electronic systems or are in the beginning stages of implementation.

There has been considerable discussion in the mental health community around confidentiality and the sharing of both mental health notes internally within organizations and across organizations. The issue of confidentiality has been identified as a major barrier to the participation of mental health providers in data sharing. It has become standard practice for mental health providers sharing records to generate less detailed progress notes, replacing traditional psychotherapy notes which contain intimate patient details as well as diagnostic information. Psychotherapy notes continue to have considerable confidentiality limitations under HIPPA.

A further complication concerning confidentiality for mental health providers are the restrictions on sharing of substance abuse information, based on 42CFR regulations. Since many of the patients served by mental health providers are dually diagnosed with substance abuse disorders, mental health providers are afraid to share data that includes substance abuse diagnostic information. While the 42CFR is national, states vary in their confidentiality guidelines. For example, some states require special considerations for family violence information. This further complicates the ability to address this issue on a national scale.

The use of physician portals, which allow outside professionals to access electronic health records through a web based portal, are an excellent opportunity for the sharing of information between mental health and other providers. The ability of mental health providers to access the physician portal in primary care electronic health record systems would help facilitate admissions in specialty mental health inpatient and outpatient programs, as the mental health provider would have access to medical clearance, diagnostic and medication information. This practice could potentially decrease the amount of time spent in psychiatric emergency rooms and reduce the testing performed in an emergency room prior to admission. The ability of emergency room providers to have access to a patients' mental health information and history could help determine a treatment path, potentially saving time and costs in emergency room settings.

Physician portals could improve service delivery for special populations, such as the developmentally disabled psychiatric population, where community residences could communicate more efficiently with both psychiatric and medical providers.

Similarly, patient portals could greatly improve care coordination for both mental health consumers and their providers, enabling mental health patients, who often use multiple systems, to have access to their records and information. This would facilitate communication with multiple providers and community services. Accessing both medical and mental health information on-line and providing accurate information to a provider could dramatically impact the assessment time needed and services provided to a patient.

Longitudinal Data Capture

Mental health providers are in an advantageous position to collect longitudinal data over time as they often see patients in outpatient settings daily in day treatment programs, or up to five times a month in traditional outpatient mental health care. Mental health providers can be trained to capture and look at longitudinal data in new ways, and collaborate with primary care providers who generally see patients less frequently. Shared data entry will allow for the collection of longitudinal data on patients with dual medical and mental health chronic illnesses.

Patient Reported Outcomes

The collection of quantifiable and patient reported outcomes is new to many mental health providers. Mental health providers using electronic health records have developed creative ways to track quantifiable outcomes, through lab values or vitals. Currently, most of the electronic records developed for mental health providers do not contain features that assist in tracking outcomes or scores for some of the more common mental health tools. These tools are more narrative in nature, yet should be reported as outcomes. The development of electronic record systems that would assist in the reporting and tracking of various mental health tools would be incredibly beneficial.

Registries

The development of registries for use by mental health providers has not been a priority and a majority of mental health providers who utilize registries work in organizations that have included mental health diagnoses in primary care registries.

There is a need for the development of registries for depression, metabolic syndrome and other diagnoses in the seriously and persistently mentally ill population. Behavioral health providers have not been trained on the use of registries or in the concept of population management. This is a critical for the development of registries in community health or mental health settings. Organizations who do not have electronic health record systems, or who have excluded mental health providers from the use of their electronic health record, should be supported in the development of Excel or Access registry tools. The mental health community needs assistance in the development and utilization of registries, even among those who are not utilizing electronic health records.

Longitudinal Care Plans

Mental health providers have a very different experience with longitudinal care plans, or treatment plans than primary care providers. Most mental health providers are accustomed to the completion of detailed treatment plans with specific goals and objectives, updated at 90 day intervals, or with any changes in diagnosis or treatment. These treatment plans are developed with the patient and are often required to be signed by the individual patient and/or their parents, caretakers or significant others. The inclusion of primary care diagnosis in the treatment plans is new for mental health providers, along with setting goals and objectives to address these medical issues.

The use of web based community portals presents a tremendous opportunity to involve multiple providers and service providers in the development and implementation of longitudinal care plans for patients. The shared use of electronic health record systems permits communication between primary care, hospital, and substance abuse providers. The inclusion of a physician portal in a mental health electronic health record systems is critical to accomplish this goal, but unfortunately, to date many of the electronic record systems designed for community mental health providers do not have this feature.

Provider List Reconciliation and Medication Reconciliation

The ability to coordinate with primary care and specialty providers to reconcile medication and problem lists has been a considerable problem for mental health providers. The confidentiality concerns surrounding sharing mental health information has led to primary care providers to feel that referrals to community mental health providers rarely result in return information. These concerns have created a culture among mental health providers that has inhibited the reconciliation of medication and problem lists with primary care providers.

To help address this, many regulatory bodies, such as state mental health agencies, are now requiring case conferencing. In New York State, new regulatory requirements for state licensed

mental health providers require a conference between the primary care and mental health provider quarterly for children receiving mental health services. Many payers are also requiring coordination between primary care and mental health providers as a part of their mental health visit authorization process. Mental health providers recognize that the barriers preventing problem list and medication reconciliation must be addressed to ensure the safety and coordination of care for mental health consumers.

2. What is the minimum data set needed to be transferred, by whom and when?

The minimum data set to be transferred includes the medication and problem list. Most mental health providers would also include the multi-axial evaluation as a critical data element. The multi-axial evaluation is used universally by mental health providers, is easily understood by other disciplines and provides an overview of diagnostic and functional information for the patient. Unfortunately, many electronic health record systems do not have the multi-axial available in a reportable or problem list format, and most behavioral health providers working in integrated settings enter this information in narrative, non-reportable fields.

3. What evidence-based quality measures exist, or would you recommend, to assess care coordination between specialists and other members of the health care team?

One of the primary steps for an organization to make towards integrating health and mental health is the implementation and utilization of tools. The utilization of tools facilitates a “common language” across providers. This is new for most mental health providers. Traditionally, mental health providers have not been trained to quantify and track outcomes, so the introduction of tools into mental health service delivery has been met with some resistance.

There are currently no evidence based tools that would measure or assess care coordination between mental health and primary care providers. However, the utilization of tools for mental health diagnosis, particularly those more commonly identified in primary care settings like depression or anxiety, could be used to monitor treatment progress, and potentially used to assess the effectiveness of care coordination efforts.

Panel 2: EHR Support of Specialists in Patient Care, including Clinical Decision Support: How can EHRs facilitate specialty care of individual patients, including use of clinical decision support?

1. How do you currently support decision making in your practice?

The development of clinical decision supports is complicated by the need for supports to both assist decision making by mental health professionals and ensure that clinicians meet regulatory requirements such as 90 day treatment planning.

Clinical decision supports could be standardized to be utilized across multiple mental health service delivery systems. Electronic health records should contain some built-in, standard, evidence-based supports. These supports need to be available for the use of the appropriate treating provider, as opposed to appearing for all providers caring for the patient.

Decisions need to be made as to how clinical decision supports are prioritized, to avoid “decision fatigue”. Evidence based tools used in clinical decision supports should be cited or referenced, and in some cases, permission must be obtained for use.

2. How do you incorporate new knowledge into EHRs (e.g., partnerships with EHR manufacturers)?

We have established organizational user and super-user groups which meet quarterly, and have designated one person to correspond with the vendor. In addition to the user groups, the Institute’s vendor has created advisory councils in topic areas such as finance, communications, nursing, pharmacy, scheduling, and training that facilitate short term communications surrounding particular issues or needs. Suggestions and requests for enhancements are given directly to the vendors by the councils.

The development of new functionality with vendors, such as the National Health Information Network (NHIN) designed to improve functionality and data exchange, is another way that new knowledge is incorporated into EHRs. Some mental health providers have developed learning communities to assist in the development of mental health functionality and to share and preserve resources. However, there continues to be a lack of resources and attention allocated to mental health providers and service delivery by electronic health record vendors.

3. How do you disseminate this new knowledge amongst your specialty?

The mental health provider learning communities continue to be a source of information sharing and dissemination of health information technology information for mental health providers. The National Registry of Evidence Based Programs and Practices (NREPP) is becoming a more commonly used resource for mental health providers. There is also increased use of the Evidence-Based Practices Implementation Website, which was developed by Substance Abuse and Mental Health Services Administration (SAMSHA) by the Center for Mental Health Quality and Accountability (CMHQA). In addition, trade organizations for mental health providers, such as the American Psychiatric Association (APA), provide information on clinical guidelines to help for mental health professionals, as do other trade organizations for social workers, counselors and psychologists.

Mental health providers are increasingly using these kinds of resources. The ability to incorporate information and resources about electronic health technology through trade organizations or national websites would be useful. Networking at conferences or other forums is also an important avenue for information dissemination for mental health providers.

4. How does your specialty generate new knowledge (e.g., clinical guidelines)?

The primary source of new knowledge is academic research conducted to address the identification, treatment, and prevention of mental illness. The implementation of electronic health records would improve the ability of community mental health providers to participate in research and expand opportunities for multi-site, multi-setting research projects.

There is an ongoing need to expand the knowledge base of mental health providers, and to narrow the gap between research findings and their translation into practice settings. Many mental health providers do not have access to research, were not trained to appropriately interpret findings, or do not think research applies to their practice settings. The ability to incorporate evidenced based clinical decision supports, which would cite research, could help bridge the gap between research and field practices, potentially decreasing the time required for research outcomes to affect field practices.