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# Information Sharing During the Opioid Crisis: Challenges and Solutions

December 12, 2018

# Agenda



- Background on Legal Barriers to Data Sharing
- SAMHSA's Targeted Capacity Expansion/ Technology-Assisted Care Program
- OhioHealth's SUD Initiative
- Q & A

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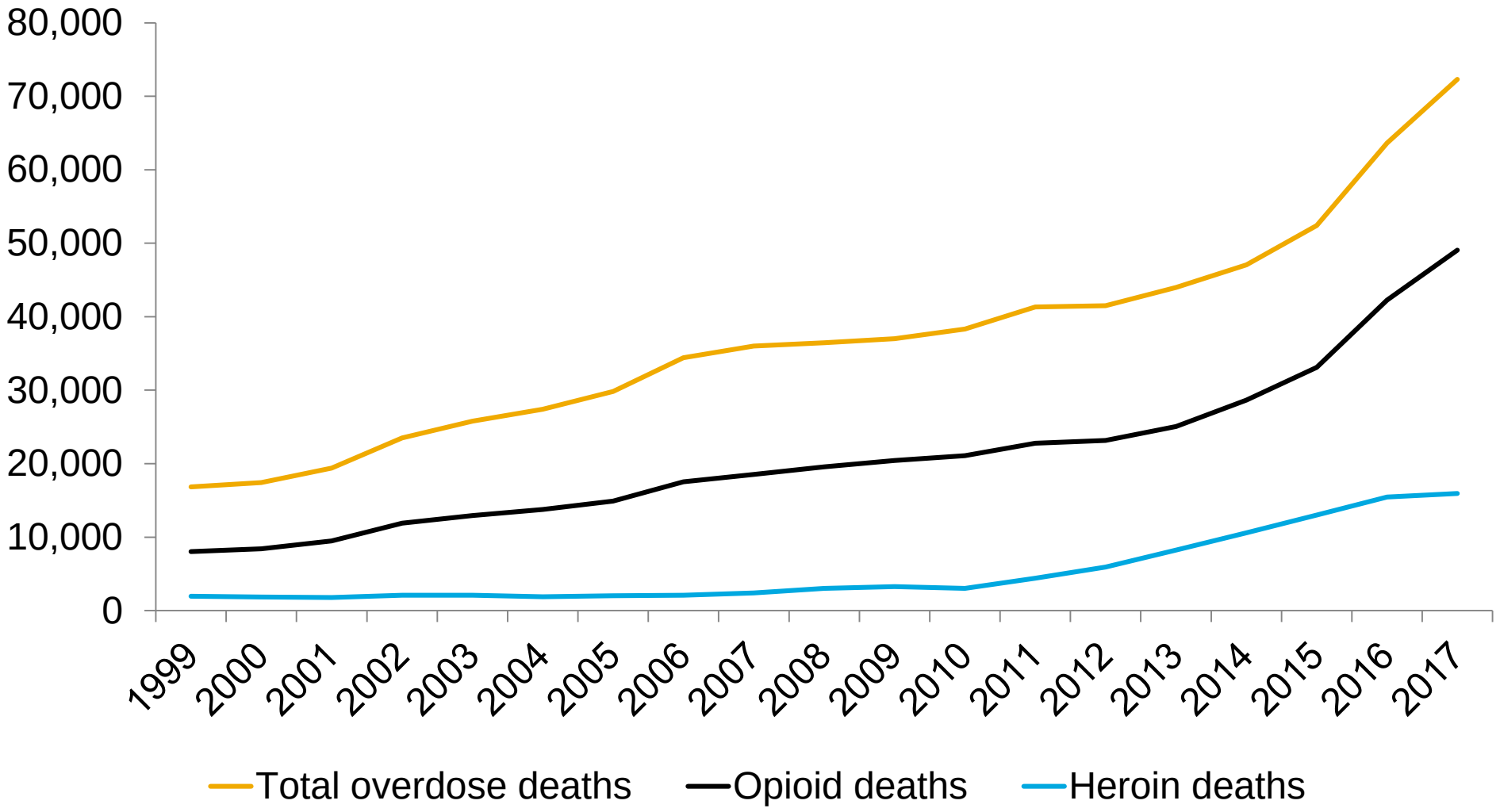
# Deaths From SUDs Continued to Increase in 2017






Source: Centers for Disease Control.

# HIPAA Generally Is Not a Barrier to Coordinating SUD Care



- HIPAA applies to Protected Health Information (PHI): information created or received by a provider, health plan, employer or health care clearinghouse that:
  - Relates to the past, present, or future health condition of an individual, or provision of a health care of an individual, and
  - Which identifies the individual (or there is a reasonable basis for identifying an individual)
- HIPAA permits covered entities (providers, health plans, health care clearinghouses) to disclose PHI for treatment purposes without patient authorization
- Treatment means the provision, coordination or management of health care and related services by a provider, and includes coordination with third parties
- Authorization is required for disclosure of psychotherapy notes, which document the content of conversations with mental health professionals

**HIPAA does <u>not</u> preempt stricter federal and state privacy laws**

# 42 C.F.R. Part 2 Is Significantly More Strict Than HIPAA



- Part 2 applies to federally assisted substance use disorder (SUD) programs
  - Provider is federally assisted if it participates in Medicare or Medicaid, is registered to dispense controlled substances, receives any federal grants, or is a non-profit
  - In order to be a "program" provider must hold itself out as providing SUD care
- Part 2 does not apply to all providers of SUD care
  - Emergency rooms generally not subject to Part 2
  - Some providers of Medication-Assisted Treatment (MAT) not subject to Part 2
- Unlike HIPAA, *Part 2 program must obtain patient consent in order to disclose for purposes of treatment*, unless a medical emergency
- Consent form must describe information to be disclosed, purpose of disclosure, and include name of recipient(s) (general designation allowed through intermediaries such as HIEs)

**House passed opioid bill revised statute underlying Part 2 in June, but Senate did not adopt in final legislation**

# HIPAA Compared to Part 2



| Issue | HIPAA | Part 2 |
|---|---|---|
| To which providers does the law apply? | Almost all providers | Federally assisted providers that hold themselves out as providing SUD services |
| Disclosure w/o consent permitted for treatment, care coordination? | Yes | No, unless it's an emergency |
| Disclosure w/o consent from provider to administrative contractor permitted? | Yes, if parties have entered into business associate agreement | Yes, if parties have entered into qualified service organization agreement |
| Does authorization form need to list the names of all potential recipients? | No | Generally yes, but general designation permitted if disclosed through an intermediary |

# State Laws Also Limit Disclosure of Behavioral Health Records



- **General Health**: Most states allow disclosure of health information for purposes of treatment without consent
  - E.g., California Confidentiality of Medical Information Act (CMIA) similar to HIPAA
  - Some exceptions: New York State has interpreted state law as requiring consent
- **Mental Health**: Variation in state laws as to whether mental health information can be disclosed
  - Massachusetts: Mental health facilities generally need patient consent; different rules for individual practitioners
  - Texas: Mental health practitioners may disclose to other professionals who participate in the diagnosis, evaluation or treatment of the patient
- **SUD**: Many states have statutes or regulations that mirror Part 2 and/or allow the state to enforce Part 2 compliance

# Legal Compliance Can Be Difficult in Practice



- The need to obtain patient consent often thwarts data sharing efforts:
  - Consents must be tracked and shared. One provider may have consent but others may not be aware.
  - Consents must contain all required information. Often difficult to meet the Part 2 requirements of listing all information recipients by name.
  - Provider holding data may have little motivation to obtain consent on behalf of other providers or honor another's consent.
- Part 2 rules often surprise practitioners
  - No Part 2 exception that allows for disclosure to prescription drug monitoring programs.
  - As a result, practitioners sometimes fear prescribing certain drugs (e.g., Xanax) because they do not know if their patient has an SUD.
  - On the other hand, many practitioners do not realize that they can participate in MAT without being subject to Part 2.

# Agenda



Background on Legal Barriers to Data Sharing

SAMHSA's Targeted Capacity Expansion/ Technology-Assisted Care Program

OhioHealth's SUD Initiative

Q & A

# Telehealth Enables Better Healthcare

*"SAMHSA's TCE-TAC Program & Telehealth"*

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***Information Sharing During the Opioid Crisis: Challenges and Solutions*** Wednesday, December 12, 2018 (1:00 p.m. to 2:00 p.m.)
eHI WEBEX

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# Our View of Telehealth

- **Telehealth**: a set of communication technologies that include real-time audio-visual (AV) interactions, asynchronous store-and-forward modalities, remote monitoring, robotics, and mobile health (mHealth).

- Different ***telehealth modalities*** support different clinical situations related to healthcare; is well established in the healthcare ecosystem & provides a foundation for expanded use of health technologies

- Telehealth supports ***attributes of high-quality care*** identified by the Institute of Medicine (IOM).
  - ↗ In certain situations, it can be as effective as in-person interactions
  - ↗ Can be more cost efficient than in-person care
  - ↗ Can increase access to equitable care for those who are isolated from health-related services
  - ↗ Can provide timely care; is person-centered, providing care when and where it is needed
  - ↗ Can be considered safe, as it can offer accurate diagnoses and appropriate treatment options to patients who do not otherwise have access to the clinical expertise needed

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# Why Isn't It More Widely Used?

- The ***challenges*** to widespread use of telehealth fall into FOUR categories:
  1) Policy
  2) Technology
  3) Implementation
  4) Reimbursement

- Major drivers of care rendered through telehealth are addressing ways to meet those challenges, the most important of which may be the "***increased demand by payers and patients for convenient and timely services***"

# SAMHSA'S TCE-TAC Program & TELEHEALTH

- Four (4) Targeted Capacity Expansion (TCE) – Technology Assisted Care (TAC) Cohorts (2011 – 2018)
  - 61 Grantees
    - Cohort 1 (29)
    - Cohort 2 (6)
    - Cohort 3 (13)
    - Cohort 4 (13)
- Organizations that implemented Telehealth (**49.1%**) or 30 of 61 Grantees
- Organizations that implemented other technology assisted care (TAC) solutions (mobile apps, texting portals, etc.) **(50.8%)** or 31 of 61
- Geographic distribution of grantees:
  - Rural (46 or 75.4%) – includes frontier
  - Suburban (13 or 21.3%) – outlying single-family housing areas surrounding larger cities and metro areas
  - Primarily Urban (2 or 3.2%) – high population; more than 1,000 people per block

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# Technologies Used to Support Telehealth & Behavioral Health Engagement
## Treatment & Recovery

- **Smartphones and tablets** enabled for mobile apps, texting and video conferencing (i.e., video on demand)
- **Interactive Websites** including virtual reality platforms, peer support services, social media and client/patient portals
- **Other Web-based Interactive tools** (e.g. CBT4CBT online therapy; adaptive technology; computer literacy assessment; yellow scheduling)

# DEMO – "TCE-TAC Aggregate Portal"

***Examples:** ***Program Implementation & Use of Telehealth in Rural Communities***

*C:\Users\wilson.washington\Desktop\tcetac-aggregate-report\index.html*

- **BACKGROUND INFORMATION – FOUR (4) COHORTS (2011-2017)**

  - ❑TCE-TAC HHS REGIONS MAP
  - ❑TCE-TAC TARGET POPULATIONS
  - ❑TCE-TAC TECHNOLOGY USED

- **LESSONS LEARNED**

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# Benefits of Telehealth

- Phones and other technology applications enable clients to use text messaging (i.e., motivational texts, appointment reminders), connect to portals, participate in video consults, etc.
- Improves & increases communication between clients and staff
- Telehealth improves access through use for intakes, screening/assessments in hospital EDs & civil commitments
- Improves revenue by matching appropriately credentialed staff to service delivery
- Makes more efficient use of staff time

# Benefits of Telehealth – Cont'd

- Improved productivity of staff in smaller county offices
- Increased efficiency through the expanded use of technology for meetings
- Use of technology for Peer Support Certification training to increase access & reduce barriers
- Increased client engagement and retention in treatment
- Improved involvement of loved ones; clients are able to include significant others in care coordination

# Lessons Learned

- Every Behavioral Health (BH) organization needs an information strategic plan and technology governance process
- Introducing new technology, or scaling up existing technology temporarily disrupts existing workflows. This needs to be anticipated and workflows designed to optimize efficiencies.
- Technology selection needs to be mindful of the customers that will be using the tools
- Actively manage technology vendor contracts

# Lessons Learned – Cont'd

- Any technology selection should employ a structured and detailed requirements definition and vetting process with end user active engagement
- Leadership engagement is critical to successful implementation and sustainability.
- Shift toward a technology enhanced value-added model.
- Adopt an evaluation plan to support workflow evolution and technology growth.

# Culture Change & Telehealth: A Critical Success Factor & C

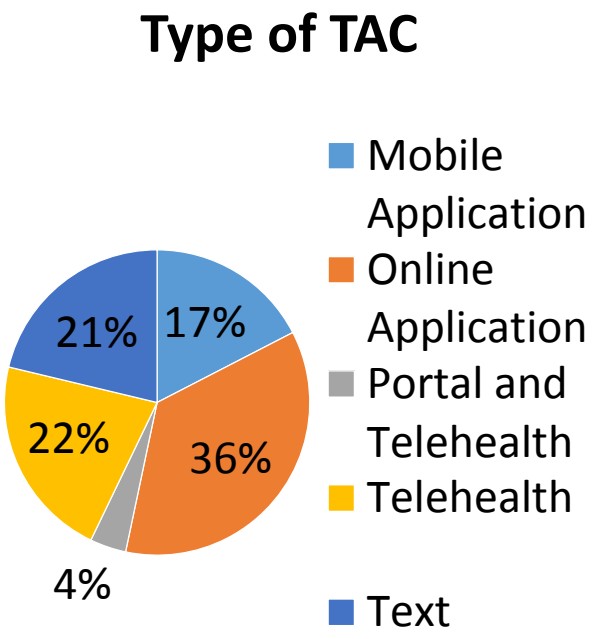
- New technologies can and should be viewed as a way to transform client engagement and interactions outside of formal clinical settings.

- Culture change needs to occur in various parts of the organization: leadership, clinical staff, physicians, finance staff, board members, etc.

- Integrated care, assumption of financial risk, quality reporting, and consumer-directed care all require significant organizational change in workflow design, data use, and workforce competencies.

- A challenge for many Behavioral Health (BH) agencies is the realization they need to spend to save. Technology is expensive and requires new sustainability funding as well as an initial investment.

# TCE-TAC Evaluation Program – Pilot Results




- Clinical Benefit[1] and Satisfaction with Techonology[2] differed between participants utilizing different types of Technology Assisted Care (TAC)
  - While clinical benefits were reported for all types of TAC, higher Clinical Benefit scores were reported by participants using telehealth at 22% (*M* = 4.41, *sd* = 0.58) than texting[3]at 21% (*M* = 3.96, *sd* = 0.48) or mobile applications[4] (*M* = 4.06, *sd* = 0.87)
  - Higher satisfaction with technology was also reported by participants using telehealth (*M* = 4.52, *sd* = 0.46) than by participants using mobile applications[5] (*M* = 4.11, *sd* = 0.73) or online applications[6] (*M* = 4.20, *sd* = 0.72)

[1]*F*(4, 277) = 4.775, *p* = .001, [2]*F*(4, 279) = 3.912, *p* = .024; [3]*p* = 001; [4]*p* = .010; [5]*p* = 004; [6]*p* = .010

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# TCE-TAC Program – Evaluation Summary

- Participants overwhelmingly agreed that the TAC Programs strongly benefitted their treatment and recovery
  - This included helping manage their symptoms, remain in recovery, manage daily responsibilities, and connect with care providers

- Participants also indicated high levels of satisfaction with the technology (agreed to strongly agreed)
  - Over 90% of participants indicated the technology was helpful to their treatment and recovery and was easy to use
  - 92% of participants indicated they would refer others

- This extremely strong support was mirrored in comments from participants showing their appreciation for these services and use of technology in treatment
  - “Can really be lifesaving!”

# Conclusion & Implications

- Nearly 300 people who are receiving TCE-TAC services responded to the satisfaction survey
- Respondents included a broad representation across gender, race, ethnicity, and age
- A factor analysis of survey items resulted in the identification of 2 factors (Clinical Benefit and Satisfaction with Technology)
- Clinical Benefit and Satisfaction with Technology were both highly rated by clients
- Client comments highlight the specific and overall benefits of using technology to support their recovery
- Results indicate the importance of continuing to provide these TAC enabled services and exploring how these technologies can be extended to more individuals in treatment and recovery from behavioral health conditions

# Did you know….?

***American Telemedicine Association (ATA) Survey - April 2017***
***Nationwide Poll of 170 Executives – ""****Identified How Healthcare Executives View Telehealth"*

- Healthcare executives see telehealth as a way to increase access for underserved patients as well as providing a competitive advantage
- 98% see telehealth as a market differentiator over other organizations that don't offer distance-based care
- 88% plan to invest in telehealth technology this year, 1% weren't going to
- 48% say consumerism will be the biggest telehealth trend between now and 2020
- 26% believe the shift to value-based care will be an incentive to adoption

# Did you know….?

***American Telemedicine Association (ATA) Survey - April 2017**
**Nationwide Poll of 170 Executives –** *"Identified Barriers to Use of Telehealth"*

- Reimbursement (71%)
- Licensure and privileges (53%)
- Resistance to change (50%)
- Lack of evidence of financial ROI or quality gains (36%)
- Provider recruitment (22%)
- Legal liability (20%)
- Bandwidth limitations (19%)
- Privacy and security (15%)

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# Health Affairs & AHRQ Studies

- Health Affairs study looked at telehealth growth between 2004 and 2014 among individuals with a mental illness diagnosis
  - Use varied widely across states
  - Average growth rate of 45% for those with any mental health condition and 49% among those with serious mental health conditions
  - Telehealth users were more likely to be under 65, have a disability making them eligible for Medicare, and worse off economically

- AHRQ analyzed 59 telehealth studies and found consistent benefits when telehealth is used for communication and counseling or remote monitoring, particularly for BH health and chronic conditions
  - Review of telehealth cost and quality cited 12 studies that show cost savings across settings.
  - Telehealth is ideally suited to individuals with BH conditions who often have challenges keeping appointments, may have frequent crises, or may benefit from a check-in with a care coordinator.

# Looking to the Future

- Any healthcare organization with funding that supports Health Information Technology (HIT) adoption should include Telehealth as a central part of its comprehensive Electronic Health Record (EHR) implementation strategy
- Healthcare agencies' HIT/EHR implementation strategy should assume bi-directional data exchange with clients and other providers using a number of technology platforms (portals, telehealth, texting, etc.)
- State and local healthcare organizations' leadership need to develop and manage a structured (written) plan for how to adopt and afford essential HIT tools
- Specific areas of focus should include: HIE, telehealth, texting and analytics- all integral to a value -based healthcare delivery solution
- Requirements for a pathway to these capabilities should be part of a comprehensive HIT/EHR adoption and implementation plan.


STOP

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# Thank you.

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

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# OhioHealth

BELIEVE IN *WE*™ OhioHealth


**OHIOHEALTH IS A NATIONALLY** recognized, not-for-profit, charitable, healthcare outreach of the United Methodist Church. Based in Columbus, Ohio, OhioHealth is currently recognized by FORTUNE Magazine as one of the "100 Best Companies to Work For." Serving its communities since 1891, it is a family of 30,000 associates, physicians and volunteers, and a network of 10 hospitals, 60+ ambulatory sites, hospice, home-health, medical equipment and other health services spanning a 47-county area.

Represents Fiscal Year 2017 Data

# WE'RE RATED

top **100** HOSPITALS 2018

BY IBM WATSON HEALTH

*(OhioHealth Doctors Hospital and OhioHealth Dublin Methodist Hospital)*


**100**

BEST COMPANIES TO WORK FOR™

BY FORTUNE MAGAZINE

**12** YEARS IN A ROW

SIX OF OUR HOSPITALS HAVE RECEIVED A SAFETY SCORE OF **A** BY LEAPFROG IN 2018

**96th** percentile IN PHYSICIAN ENGAGEMENT

BY PRESS GANEY

**$3.8b** IN OPERATING REVENUE

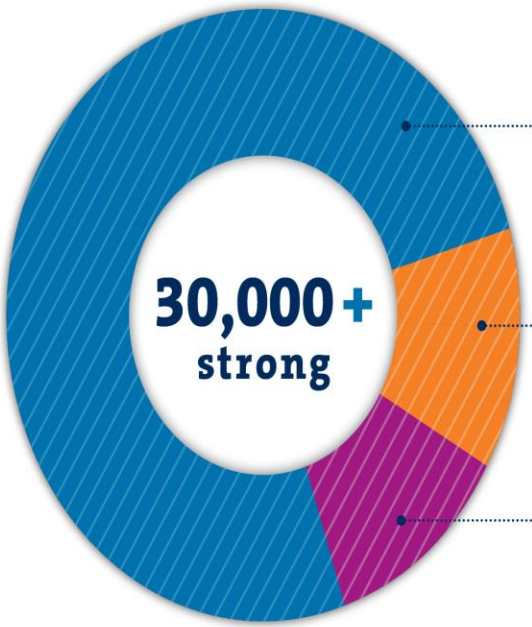
FINANCIAL STRENGTH RATINGS

AA+ BY STANDARD & POOR'S
Aa2 BY MOODY'S
AA+ BY FITCH

Represents Fiscal Year 2017 Data

# WHO WE ARE & WHAT WE DO

***WE*** **are a faith-based, not-for-profit healthcare system.**




**25,100**
ASSOCIATES

**3,400**
PHYSICIANS

**370+**
RESIDENTS & FELLOWS

**2,200**
VOLUNTEERS

**3.0m**
OUTPATIENT VISITS

**510,196**
ED VISITS

**169,951**
ADMISSIONS & OBSERVATIONS

**108,166**
SURGERIES

**15,147**
BIRTHS

**500**
CLINICAL TRIALS

Represents Fiscal Year 2017 Data

# WHERE WE ARE

## care site locations

### hospital

1. OHIOHEALTH RIVERSIDE METHODIST
2. OHIOHEALTH GRANT MEDICAL CENTER
3. OHIOHEALTH DOCTORS HOSPITAL
4. OHIOHEALTH GRADY MEMORIAL
5. OHIOHEALTH DUBLIN METHODIST
6. OHIOHEALTH HARDIN MEMORIAL
7. OHIOHEALTH MARION GENERAL
8. OHIOHEALTH O'BLENESS HOSPITAL
9. OHIOHEALTH MANSFIELD HOSPITAL
10. OHIOHEALTH SHELBY HOSPITAL

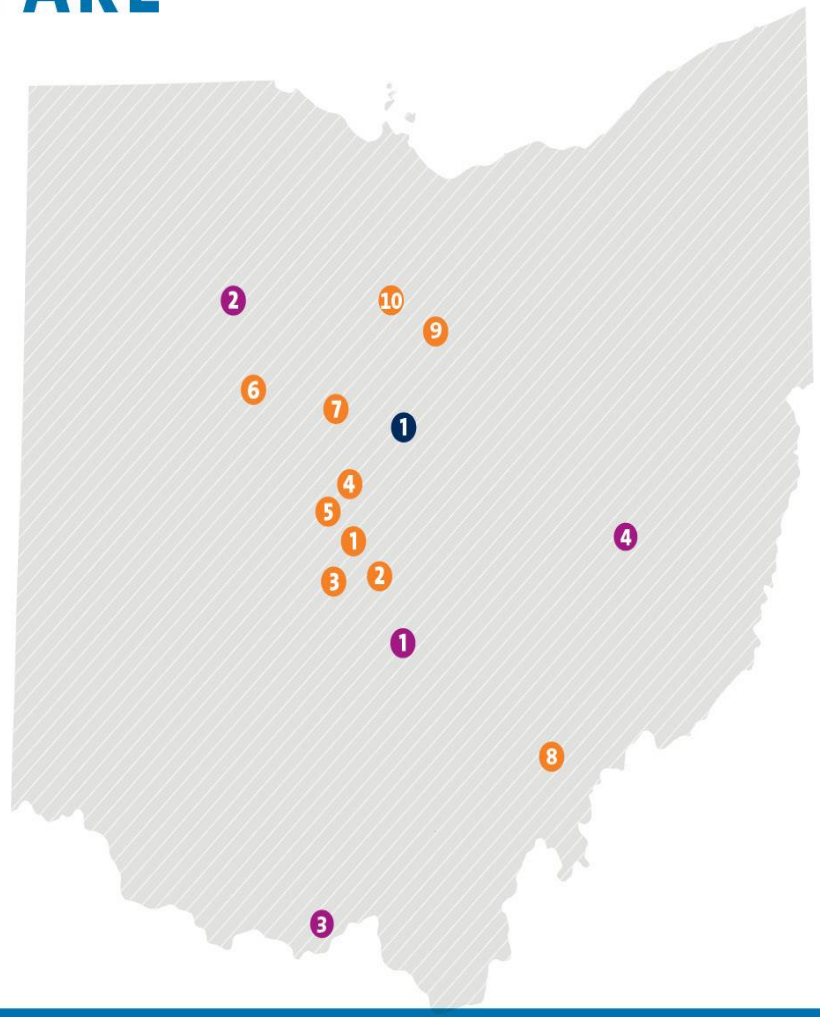
### managed

1. MORROW COUNTY HOSPITAL

### affiliate

1. BERGER HEALTH SYSTEM
2. BLANCHARD VALLEY MEDICAL CENTER
3. SOUTHERN OHIO MEDICAL CENTER
4. SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER

**60+**
**OUTPATIENT LOCATIONS**




Represents Fiscal Year 2017

OhioHealth

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