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Strategies for Complying with New ONC Data Sharing Rules, Including Collaborative Documentation

Regulatory Basis, Research, and Operational Considerations

Disclaimer

None of the information presented should be construed or relied upon as legal advice.

Faculty

Dr. Joe Parks, MD.

Medical Director, National Council for Mental Wellbeing

Joe Parks, M.D., currently serves as medical director for the National Council and is a distinguished research professor of science at Missouri Institute of Mental Health with the University of Missouri, St. Louis. He also practices outpatient psychiatry at Family Health Center, a federally funded community health center established to expand services to uninsured and underinsured patients in Columbia, Mo.

Dr. Parks is the national behavioral health representative at large for The Joint Commission. He previously served as the director of Missouri MO HealthNet Division (Missouri Medicaid) in the Missouri Department of Social Services and was medical director for the Missouri Department of Mental Health in Jefferson City and the Division Director for the Division of Comprehensive Psychiatric Services.

Dr. Parks has conducted research and published in the areas of implementation of evidence-based medicine, pharmacy utilization management, integration of behavioral health care with general health care, and health care policy. He has received numerous awards for improving the quality of care and leadership.

Faculty

Michael Flora, MBA, M.A.Ed., LCPC

Senior Management and Operations Consultant and Senior National Council Consultant

As MTM's Senior Operations and Management Consultant, Michael brings over 30 years of experience in clinical practice and behavioral healthcare administration, with a focus in strategic planning, performance improvement and workforce development. Across his career, Michael has served as president and chief executive officer of several multimillion dollar behavioral health organizations and their subsidiaries. He is a highly sought after national speaker and consultant and has worked with more than 300 organizations to implement executive leadership coaching and training initiatives as well as board governance and clinical, operational and financial consultation and training.

Michael's writing has been featured in numerous mental and behavioral health publications and he served as adjunct faculty at Northern Illinois University. He holds the highest level of clinical licensure in Counseling as a Licensed Clinical Professional Counselor and is a member of the American College of Healthcare Executives.

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Faculty

Dr. Valerie Westhead, MD.

Medical Operations Consultant and Senior National Council Consultant

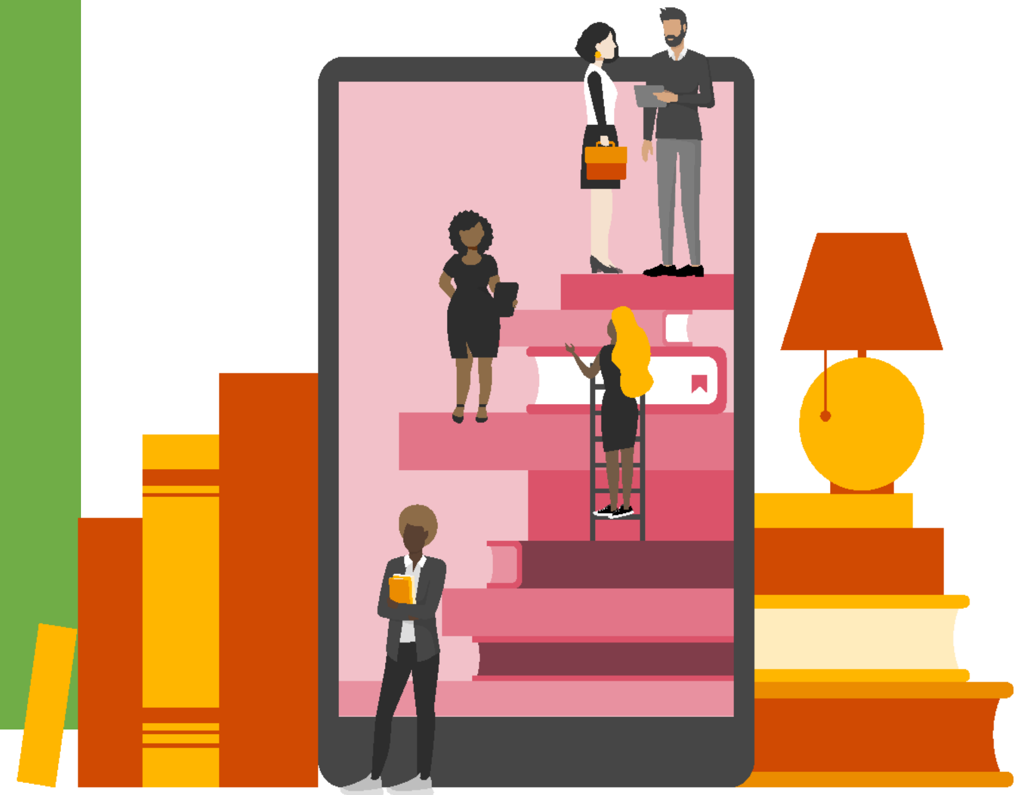
Dr. Westhead is board certified in psychiatry and addiction medicine whose work focuses on the intersection of mental health/substance use disorders and the criminal justice system. Dr. Westhead helps providers develop and implement integrated services that respond to the complex needs of today's patient population in the communities in which they live. Often working in conjunction with civic partners – from problem solving courts to juvenile detention facilities and direct treatment providers to community action committees – she brings organizations and systems together to fulfill their essential roles in patient recovery and wellness.

In addition to her work with MTM, Dr. Westhead is the chief medical officer at Aspire Health Partners, a comprehensive community behavioral healthcare organization serving Central Florida. She is the psychiatric consultant to the Seminole County Sheriff's Office, where her duties include providing psychiatric care in the adult and juvenile correction system as well as working with the problem-solving court system that includes drug, mental health and drug courts. She is chair of the Mental Health and Substance Abuse Task Force in Seminole County, which brings treatment providers, criminal justice leaders, and government officials together to work on meaningful change to improve the care of those struggling with mental health and addiction conditions.

Overall goals of the new Interoperability rules

This is a regulatory push by CMS and ONC that aims to shift the way the healthcare system shares data, moving from a system where healthcare organizations ***may*** share data under HIPAA to one where they ***must*** share data

- Data moves with patient from provider to provider, and from health plan to health plan
- Patient data is made available through mobile and web-based apps
- Freer flow of data empowers patients and helps improve value-based care efforts



The ONC and CMS rules apply to....

Providers

- Make Patient health information (EHI) available through Application Programming Interfaces (APIs)
- Provide electronic notification to other providers when a patient is admitted, discharged or transferred (ADT)
- Information blocking prohibited

Payers

- Patient claim /health data (EHI) made available through APIs
- Patient data shared with other payers as they move from health plan to health plan

HIT Developers

- Use APIs
- New Certification requirements

Third-Party Apps

- Use APIs
- Transition from use of CCDA to the new USCDI

*EHI – (final rule) is defined as ePHI to the extent that it would be included in a designated record set.

Important Dates

- April 5, 2021 - **Information blocking prohibited**
  - Electronic health information (EHI) definition is limited to only information defined in United States Core Data for Interoperability (USCDI) standards
  - USCDI standards expanded to include progress notes
  - Only data in USCDI standards must meet interoperability requirements on HIEs

- May 1, 2021 – ADT Notifications Required

- October 6, 2022
  - EHI definition is expanded beyond defined elements in USCDI to include any information that an organization has that is:
    - (i) Transmitted by electronic media;
    - (ii) Maintained in electronic media; or
  - The above definition includes information and other provider impaired data systems beyond the EMR alone

- December 31, 2023
  - Providers and payers required to have full export capability for all their EHI

What data needs to be shared?

- *Within the first 24 months – expands to HIPAA data set after 24 months*

- Allergies and intolerances
- Assessment and Plan of Treatment
- Care Team Members
- Goals
- Health Concerns
- Immunizations
- Laboratory
- Medications
- Patient Demographics
- Problems
- Procedures
- Provenance
- Smoking Status
- Unique Device Identifier(s)
- Vital Signs
- Clinical Notes*
  - Consult Note
  - Discharge Summary
  - H&P
  - Imaging Narrative
  - Pathology Narrative
  - Procedure
- Progress Note

Standards:
https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi

** Currently not part of Netsmart CCD Standard*

Scope of ONC Rule

ONC Rule covers two main areas: Information Blocking and HIT Certification Criteria

Information Blocking

A practice by a healthcare provider, HIT developer, or HIE/HIN that, *except as required by law or specified by the Secretary as a reasonable and necessary activity*, is likely to interfere with, prevent, or materially discourage access, exchange or use of EHI.

Information Blocking Exceptions

- Preventing Harm
- Privacy Exception
- Security Exception
- Infeasibility Exception
- HIT Performance Exception
- Content and Manner Exception
- Fees Exception
- Licensing Exception

More on Exceptions

- EHRs with the capability to give patients direct and immediate access will generally need to provide instant access. If you keep EHI but do not have an EHR that allows for direct and immediate patient access will likely come under the infeasibility exception to the instant access requirement.
- May exclude notes of any type that may cause harm to the patient or others should the patient have access. However, the rule specifically states that psychological distress does not meet the definition of harm (Torous, 2020). “Substantial Harm” meaning life threatening or physical harm.
- To exercise the privacy exemption the patients request to not share EHI must be documented in the record

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Psychotherapy Note Exception

- Psychotherapy notes are exempt from the information blocking prohibition
- Psychotherapy Notes cannot include:
  - Any documentation information required for billing
  - History, symptoms, mental status exam, therapist interventions
- Psychotherapy Notes Are
  - Documentation about the therapist's emotional reactions, fantasies, and internal associations that occur in relation to the patient
  - i.e. Traditional psychoanalytic process notes
- To be exempt from information blocking psychotherapy notes must be kept entirely separate from the rest of the patient record
- Uncertified EHRs such as PsyBooks are not required to follow the Open Notes Rule

Psychotherapy with content that is considered medical record notes cannot be blocked.

- Diagnosis
- Symptoms
- Functional status
- Treatment plans
- Prognosis
- Progress to date
- Session start and stop times
- Test results
- The modalities and frequencies of treatment furnished
- Medication prescription and monitoring

IT Considerations

- EMR Vendors are required to have their EMR capable of meeting the ONC requirements in order to be ONC/CMS certified which is a requirement for submitting billing to CMS
  - The EMR internal capability to extract and export patient information is likely to be implemented as part of a regular EMR update without additional cost
  - The ability to provide access to the exported data via a patient portal or connection to an HIE is usually a functional module that must be purchase/subscribe to separately from the basic EMR package
- The information blocking exception for privacy requires specific documentation that the patient has requested that their information not be shared. Uniformly encouraging patients to exercise this is considered information blocking.
- There are currently no penalties for providers not complying with the interoperability requirements. CMS has stated that disincentives for noncompliance will be implemented in the future

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OpenNotes (aka Concurrent Documentation) Research

- In 2010, Beth Israel Deaconess, Geisinger Health System, and Seattle's Harborview Medical Center did a study involving 105 primary care doctors with 20,000 of their patients able to read their clinical notes via secure online patient portals.
    - Doctors reported little change in workload and clinician fears were unfounded.
    - Patients overwhelmingly approved of note sharing; few were worried or confused by their notes.
    - patients reported that reading notes helped them feel more in control of their health and health care.
    - 25% reported finding errors- most commonly diagnosis, history and medication

- OpenNotes in Mental Health
    - VA study - patient experiences are more positive than negative when reading mental health notes
    - Beth Israel Deaconess Medical Center study
        - 94% agreed that having open therapy notes is a good idea and 87% wanted it to continue.
        - More than half reported therapy notes were 'very important'... for feeling in control of their care, trusting their providers and taking care of themselves.
        - Two felt offended, and 7 (11%) felt judged by something they read in a note.

Collaborative Documentation

- Collaborative documentation is a practice where clinician and patient document together, during the session.
- Collaborative documentation = (Concurrent Documentation + Shared Decision-Making) X Patient centered
- Advantages
  - Reduces errors and misunderstandings
  - Enhances patient engagement and empowerment
  - Documentation is always completed on time by the end of the session
  - Patients are never surprised when they read the note

Training available Through MTM and the National Council

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Collaborative Documentation

What is Collaborative Documentation?

- Collaborative Documentation is a process in which clinicians and clients collaborate in the documentation of the Assessment, Service Plan, and Progress Notes.
- CD is a clinical tool that provides clients with the opportunity to provide their input and perspective on services and progress, and allows clients and clinicians to clarify their understanding of important issues and focus on outcomes.
- The Client must be present and engaged in the process of documentation development.

Resent Research

"The practice appeared to improve trust through increased transparency, and created a platform for providing feedback to clients that prompted insights into behaviors and cognitions more quickly than before. Ultimately, therapist comfort level and skills appeared to influence the adoption of a collaborative documentation process".

DiCarlo, Robert C. (2017) *Collaborative documentation in community behavioral health: The impact of shared record keeping of therapeutic alliance.* Doctoral thesis, Northern Arizona University.

Client Benefits with CD

- Increased engagement
- Clients participate in their treatment goals and discussion of progress = Client-Centered Treatment.
- Opportunity to provide valuable feedback to the clinician– what is working, what is not working.

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Increased Engagement

- Teams who implement CD see about a 10% increase in client show rates immediately after implementation.

Collaborative Documentation

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- CD is a Tool not a Rule
- CD is a Staff Self Care Tool
- CD is part of the Clinical Intervention
- CD promotes client engagement and participation in treatment
- The Client must be present and engaged in the process of documentation development.

What is Collaborative Documentation?

Simply…it is a model of documenting the session content and process with the Person Served/family "at the same time" he/she/they are still present in the session with the service provider. Basically it involves incorporating an active discussion at the end of the service encounter and documenting the information provided in the electronic clinical record (EMR).

Wellbeing

What is Collaborative Documentation?

CD allows the service provider to confirm with the consumer/family in a proactive manner:

The goals and objectives addressed during the session

The therapeutic interventions provided by the direct care staff

Their feedback regarding progress made and an indication of their perceived benefit of the service.

In addition, this practice is an appropriate extension of the therapeutic interaction that could serve to focus the client/family on what just occurred in the session as well as their next steps in the process of recovery/resiliency.

What is Collaborative Documentation?

- Client and clinician are engaged in completing documentation together
- Changing Perspective from documenting about the client to documenting **with** them.
- Promotes client centered care
- Encourages and motivates client
- Supports shared decision making
- Can be utilized as a clinical tool to engage client in treatment

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What are the Current Documentation Struggles

Documentation is currently thought of as **“paperwork”** vs. establishing the difference between paperwork and clinical documentation

Staff struggle to find the time to complete their documentation

Staff celebrate when clients no-show to complete Clinical Documentation

Documentation time competes with client time

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What are the advantages to Collaborative Documentation?

Clinical Benefits

- CD provides clients the opportunity to provide their input and perspective on services and progress.

- CD supports providers and clients (including family unit) the opportunity to continuously review treatment needs, obstacles, goals and progress.

- CD supports increased engagement, involvement and achieved treatment outcomes.

What are the advantages to Collaborative Documentation?

Documentation Timeliness

- Keep Documentation In Real Time
- Accuracy of documentation increased when not trying to recall interaction
- Care coordination and risk management
- Supports timely communication with other providers
- Saves and average of 4-8 hours of staff time per week

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What are the advantages to Collaborative Documentation?

True “Informed Consent”

- Clients sign HIPAA forms but do they know what is in their chart

- When a client signs a consent form do they know what is being shared

Benefits of Collaborative Documentation

To the Consumer/Family:

Involves consumer/family in the therapeutic process and recording of session content and process (review, feedback, description, insight);

Empowers consumer/family to know and determine the course of clinical assessment, interventions and progress of therapy.

Real time feedback will increase consumer/family “buy-in” to therapy

Cutting out-of-session documentation time results in increased hours per clinician per year for direct service, thus serving more consumers/families.

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Benefits of Collaborative Documentation

To Staff:

Because clinicians will clarify their impressions and therapeutic interventions by putting them into words in front of the consumer/family, this enhances the therapeutic value of the session.

Ensures greater content accuracy b/c of reduced time between the actual service and writing the progress note;

Eliminates the staff's "treadmill" of always having to catch up on documentation of services, that is, to keep paperwork timely and accurate.

Can save up to 8 hours per week (or 384 hours per year) in documentation time.

With increased time availability, this allows clinicians to be less anxious about accepting and seeing more consumers on their caseload at any one time.

Conversion to CD is accompanied by a drop of up to 25% in staff sick time usage

Benefits of Collaborative Documentation

To the Agency:

Sets a standard for clinical formulation among all staff to assure documentation completeness, consistency, and compliance with all applicable state, federal and accreditation standards.

Increased documentation compliance would lower likelihood of paybacks via audits

Staff's increased availability could help service clients with other payer sources and/or a larger penetration rate of Medicaid clients.

Increased staff morale and enhance quality of life would reduce staff burn-out and turnover rates.

What do the clients say?

Collaborative Documentation Pilot Client Survey Results

1. On a scale of 1 to 5, how helpful was it to you to have your provider review your note with you at the end of the session?		Percentages	
		Total	Total %
1	Very Unhelpful	1195	4%
2	Not helpful	352	1%
3	Neither helpful nor not helpful	2564	9%
4	Helpful	8888	31%
5	Very Helpful	14988	52%
NA	No Answer/No Opinion	756	3%
	Total/Approval %:	**28,743**	**94%**

2. On a scale of 1 to 5, how involved did you feel in your care compared to past experiences (either with this or other agencies)?		Total	Total %
1	Very Uninvolved	625	2%
2	Not involved	255	1%
3	About the same	3722	13%
4	Involved	7714	28%
5	Very Involved	14672	53%
NA	No Answer/No Opinion	817	3%
	Total/Approval %:	**27,805**	**97%**

Collaborative Documentation Pilot Client Survey Results

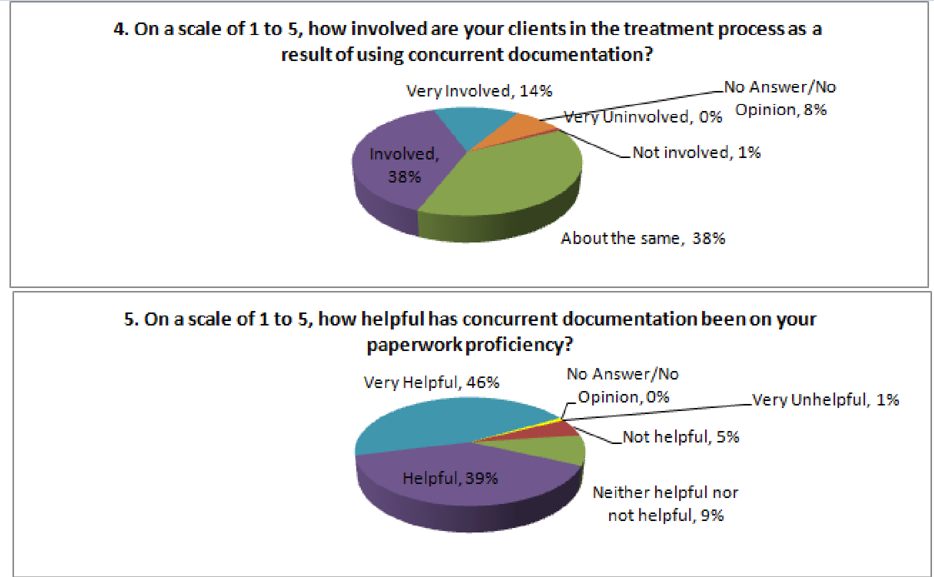
3. On a scale of 1 to 5, how well do you think your provider did in introducing and using this new system?	Total	Total %
1 Very Poorly	113	0%
2 Poorly	62	0%
3 Average	1136	4%
4 Good	6561	24%
5 Very Good	19331	70%
NA No Answer/No Opinion	531	2%
Total/Approval %:	27,734	99%

4. On a scale of 1 to 3, in the future, would you want your provider to continue to review your note with you?	Total	Total %
1 No	1440	5%
2 Unsure	3276	12%
3 Yes	20687	77%
NA No Answer/No Opinion	1527	6%
	0	0%
	0	0%
Total/Approval %:	26,929	94%

Collaborative Documentation Pilot Staff Survey Results

4. On a scale of 1 to 5, how involved are your clients in the treatment process as a result of using concurrent documentation?	Total	Total %
1 Very Uninvolved	0	0%
2 Not involved	1	1%
3 About the same	43	38%
4 Involved	43	38%
5 Very Involved	16	14%
NA No Answer/No Opinion	9	8%
Total/Approval %:	112	99%

5. On a scale of 1 to 5, how helpful has concurrent documentation been on your paperwork proficiency?	Total	Total %
1 Very Unhelpful	1	1%
2 Not helpful	6	5%
3 Neither helpful nor not helpful	10	9%
4 Helpful	44	39%
5 Very Helpful	51	46%
NA No Answer/No Opinion	0	0%
Total/Approval %:	112	94%



Collaborative Documentation Requires a Shift in Thinking

- Changing perspective from “documenting about the client” to “documenting our interactions with the client

- Be prepared to be more **transparent** as a provider!

- Remember that it is OK to **Agree to Disagree**!
  - One common fear among service providers is that clients will resent or disagree with what is being documented.

Be prepared to **shift your language.** Using clinical/technical terminology can negatively impact treatment. Use clients language and terms that client can understand and/or relate to.

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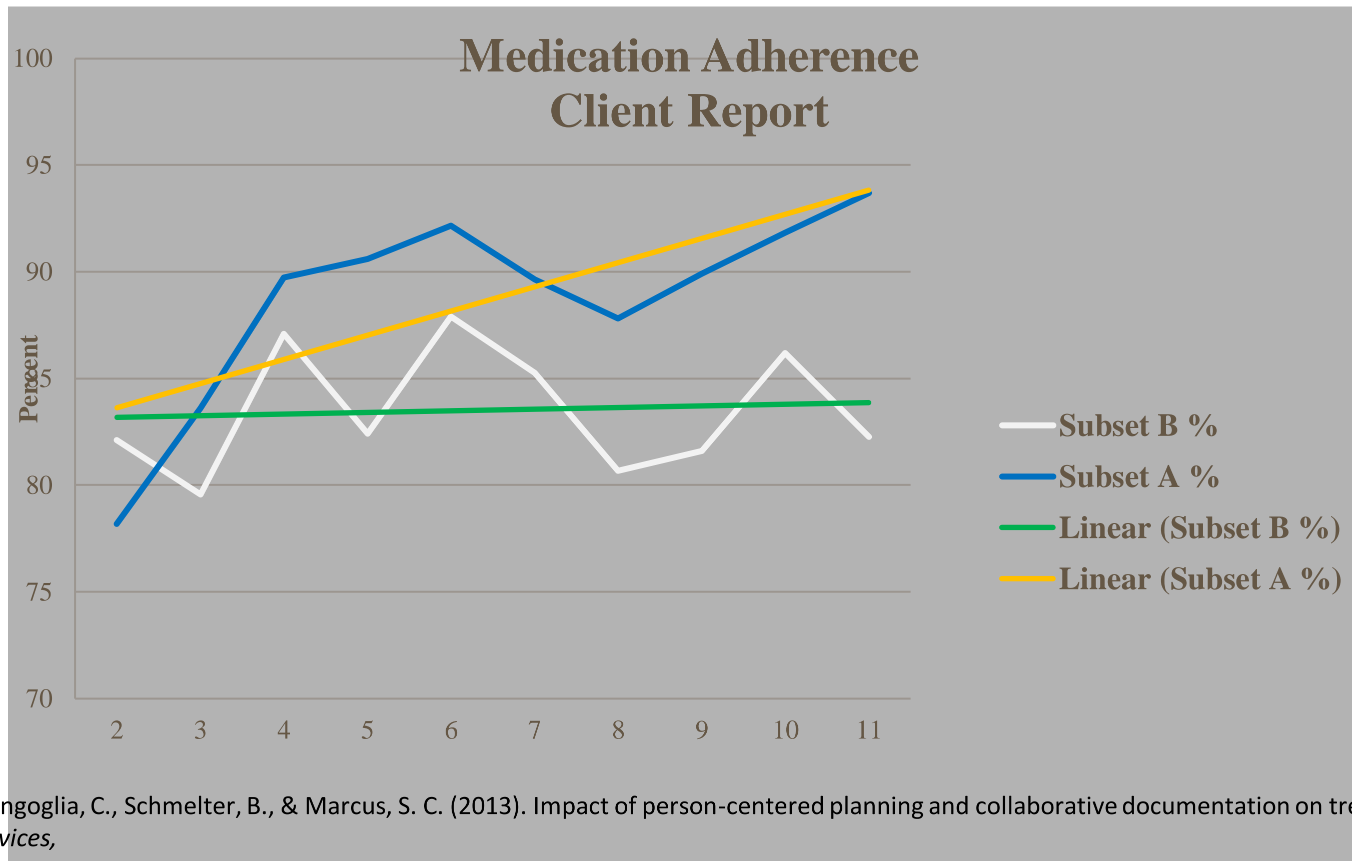
Collaborative Documentation As part of the Clinical Intervention

10 Center Access and Engagement Project
National Council for Community Behavioral Healthcare

1. **AtlantiCare Behavioral Health** - Egg Harbor Township, NJ
2. **Avita Community Partners** - Flowery Branch, GA
3. **Carlsbad Mental Health Center** – Carlsbad, NM
4. **Cascadia Behavioral Health** – Portland, OR
5. **Colorado West Regional Mental Health** – Glenwood Springs, CO
6. **Counseling Services of Eastern Arkansas** – Forest City, AR
7. **The H-Group, Inc. (Franklin-Williamson Human Services)** – West Frankfort, IL
8. **Northside Mental Health Center** – Tampa, FL
9. **Ozark Guidance Center** – Springdale, AR
10. **The Consortium, Inc.** – Philadelphia, PA

10 Center Access and Engagement Project
National Council for Community Behavioral Healthcare

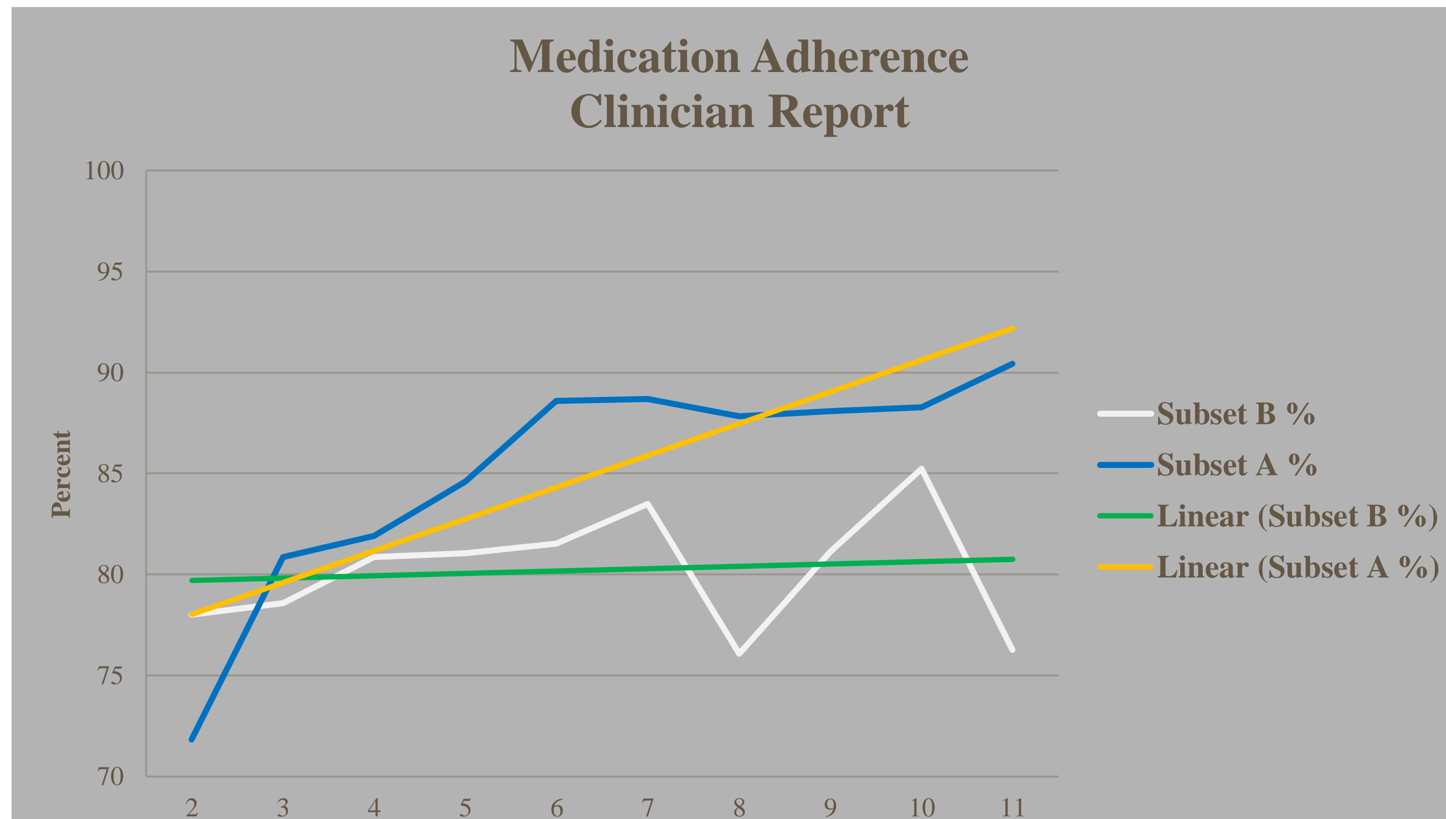
Medication Adherence
Client Report



Stanhope, V., Ingoglia, C., Schmelter, B., & Marcus, S. C. (2013). Impact of person-centered planning and collaborative documentation on treatment adherence. *Psychiatric Services,*

10 Center Access and Engagement Project
National Council for Community Behavioral Healthcare

Medication Adherence
Clinician Report



Stanhope, V., Ingoglia, C., Schmelter, B., & Marcus, S. C. (2013). Impact of person-centered planning and collaborative documentation on treatment adherence. *Psychiatric Services,*

The Evidence is in:
Doctors See Value in Sharing Visit Notes with Patients

Annals of Internal Medicine *10-2-2012*

The study shared findings from OpenNotes, a Robert Wood Johnson Foundation-supported initiative in which, over the course of one year, 105 doctors shared their notes with more than 19,000 patients at three health centers around the country—Beth Israel Deaconess Medical Center in Boston; Geisinger Health System in Danville, Pa.; and Harborview Medical Center in Seattle.

The study revealed that patients who participated in OpenNotes felt more in control of their health care, experienced improved recall of their care plan, and reported they were more likely to take their medications as prescribed. Doctors' fears about the added time burden and offending or worrying patients did not materialize, and many doctors reported that note-sharing strengthened their relationships with patients, including enhancing trust, transparency, communication, and shared decision-making.

Collaborative Documentation Strategies

General Tips:

- Assume that your clients will read their documentation at some point.
- Let clients see the computer/ documentation as it is being developed
- Agree to disagree!
- Do as much as you can.
- Identify the aspects of documentation that are most important to do collaboratively.
- Start with clients that you think will be receptive and who you are comfortable with. Then continue implementation from there.
- Start the process with new clients right away.

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Sample "Office" Setup

Can your Person Served see your screen?

Medical Practice Synergy – CD and E/M

- 2021 Documentation Standards and Expectations Align with CD
- Medical Necessity – HPI/ROS/Psychiatric Examination
  - Individualized description of symptoms and functional impairments
  - Precise description of client's self-directed activities and goals
  - Improved client education about diagnosis and benefits of treatment
- Data Review – Improve integration and objective team-based care delivery
- Medical Decision Making
  - Treatment risks, benefits and alternative choices
  - Less than optimal outcomes drive changes in treatment
  - Exploring the impact of not taking action
- Diagnosis Update – demonstrating the impact of treatment

Encounter Focuses on Treatment Plan … and Shared Responsibility

- Start Sessions with Medical Decision Making from the last appointment
- Review actions taken since last encounter – Provider/Treatment Team and Client
- Document impact
  - Symptoms and functioning
  - Psychiatric Examination
  - Data
- Medical Decision Making
  - Goals – resolution, modified and additions
  - Treatment – maintenance/modifications

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Improving Healthcare Consumer Skills

- Client Participation Drives Engagement
  - Focusing on the client's context of strengths, needs, abilities preferences and barriers
  - Active partner in evaluating treatment and outcomes – Are there unmet goals?
  - Reviewing an Adjusting goals and diagnosis at every encounter
  - Creates curiosity and a desire to consider possibilities
- Client benefit –Increased self awareness and engagement in treatment … which usually leads to improved outcomes!

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Outcomes

- Documentation becomes a clinical tool – not "paperwork"
- Open notes are therapeutic
- Internal treatment silos – medical, clinical, mental health, SUD - are eliminated as all team members engage in CD, review service delivery documents across all disciplines with consumers, and create a cohesive and comprehensive treatment experience for individual services
- Staff recognize the value of care integration and experience improved work -life balance
- Treatment is compliant with Value Based Care expectations

Implementation to Do List

- Contact your EMR vendor find out the details of how they will be implementing the interoperability requirements
- Review and Revise Policies forms and procedures for:
    - Providing information to patients and other healthcare providers
    - Requesting information from other healthcare providers including ADT from hospitals
    - Documenting privacy exemption to information blocking
- Review and Revise Patient education materials
- Staff training program
    - Policies and procedures listed above
    - Open notes and/or collaborative documentation