

Advancing Mental and Behavioral Health Integration Through Health Information Exchange

Dr. Kate Junger, Cincinnati Children's Hospital

Diane King, NewPath Child and Family Solutions

Dan Paoletti, CliniSync

A Story in Three Parts

- ***Breaking Down Siloes of Care Through Improved Data Sharing*** - Hospital Partner Perspective
- ***Using Data Sharing to Improve Continuity of Care*** – Community Partner Perspective
- ***Current State and Future Vision for Integrated Data Sharing*** – State HIE Perspective

Breaking down siloes of care through improved data sharing

Dr. Kate Junger
Pediatric Psychologist
Professor of Pediatrics
Director of Systems Integration, Office of Population Health
Cincinnati Children's Hospital

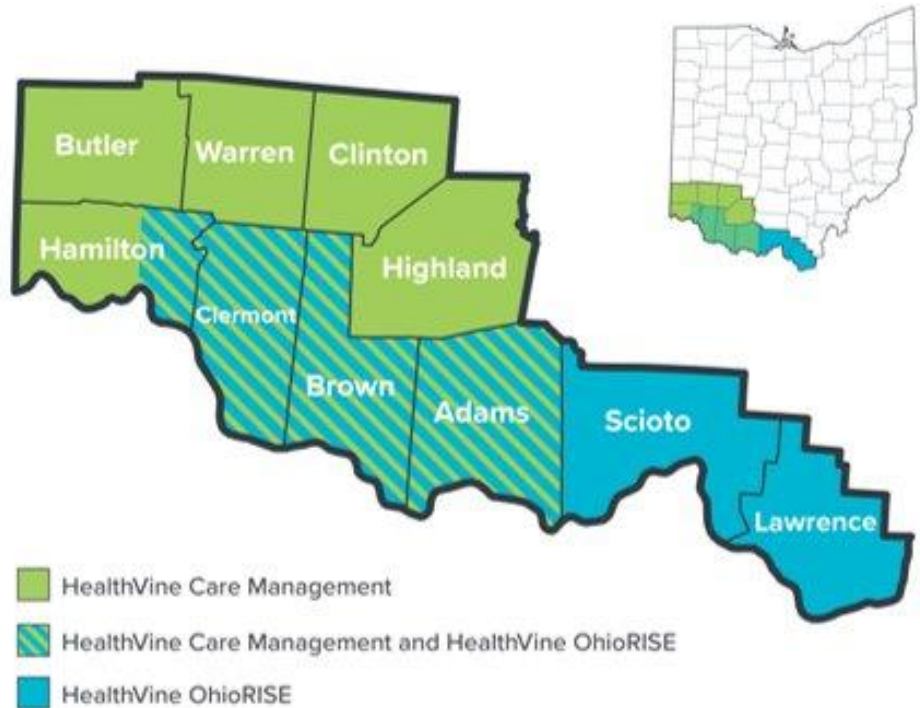
HealthVine Overview

Currently, HealthVine serves **130,000 Medicaid-covered*** youth up to age 19 as well as young adults ages 19 to 21 in the Aged Blind and Disabled (ABD) program who reside in eight counties in Southwest Ohio including Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland and Warren.

In addition, HealthVine **OhioRise** serves Medicaid eligible youth in Eastern Hamilton, Clermont, Brown, Adams, Scioto, and Lawrence Counties.



HealthVine Partners



HealthVine is a network of community and hospital-based providers working together to make healthcare **accessible** and **affordable** to children across Southwest Ohio.

Through our financial incentive programs, both **behavioral health** and **primary care** organizations are rewarded for their contributions towards improving health and well-being of HealthVine members.

22
Behavioral
Health Orgs

22
PCP
Groups

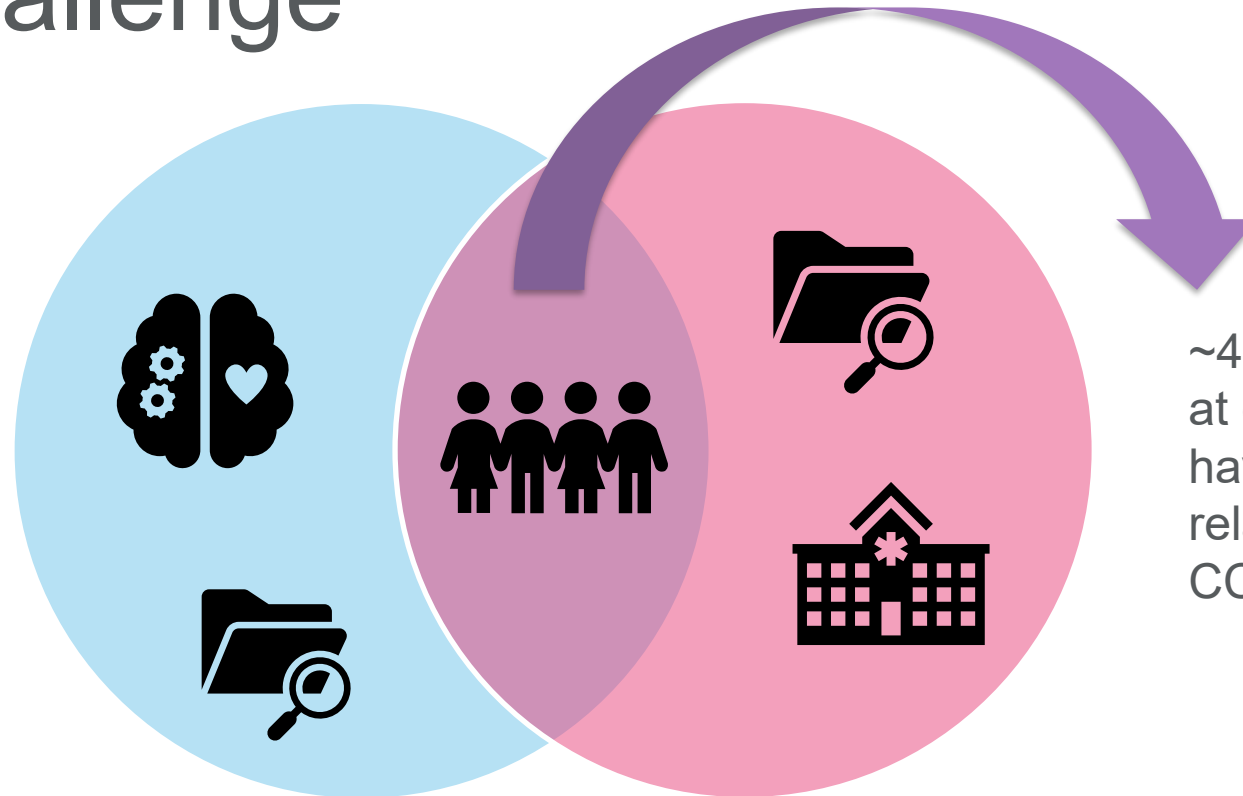
Youth with MH conditions drive cost

- ~1 out of 5 youth has a mental health condition
- 55% of Medicaid spend in 3-17yos traces to youth with MH conditions
- Physical health comorbidities are common
 - Out of youth with a MH condition and typical spend, ~2/3 had a chronic physical health condition
 - 95% of high spend youth had a chronic physical health condition
- In MH population, general medical hospitalizations were biggest cost driver.

Implication:

Integrating physical and mental healthcare is essential.

Shared patients, Separate Data: The Silo Challenge



~4 out of 5 active patients
at our partner CMHCs
have treatment
relationships with
CCHMC

Despite serving the same patients, data systems remain disconnected, creating gaps in care coordination and outcomes.

Epic Link: Increasing Information Access for External Community Mental Health Centers (CMHCs)

Epic Link Unlocks:

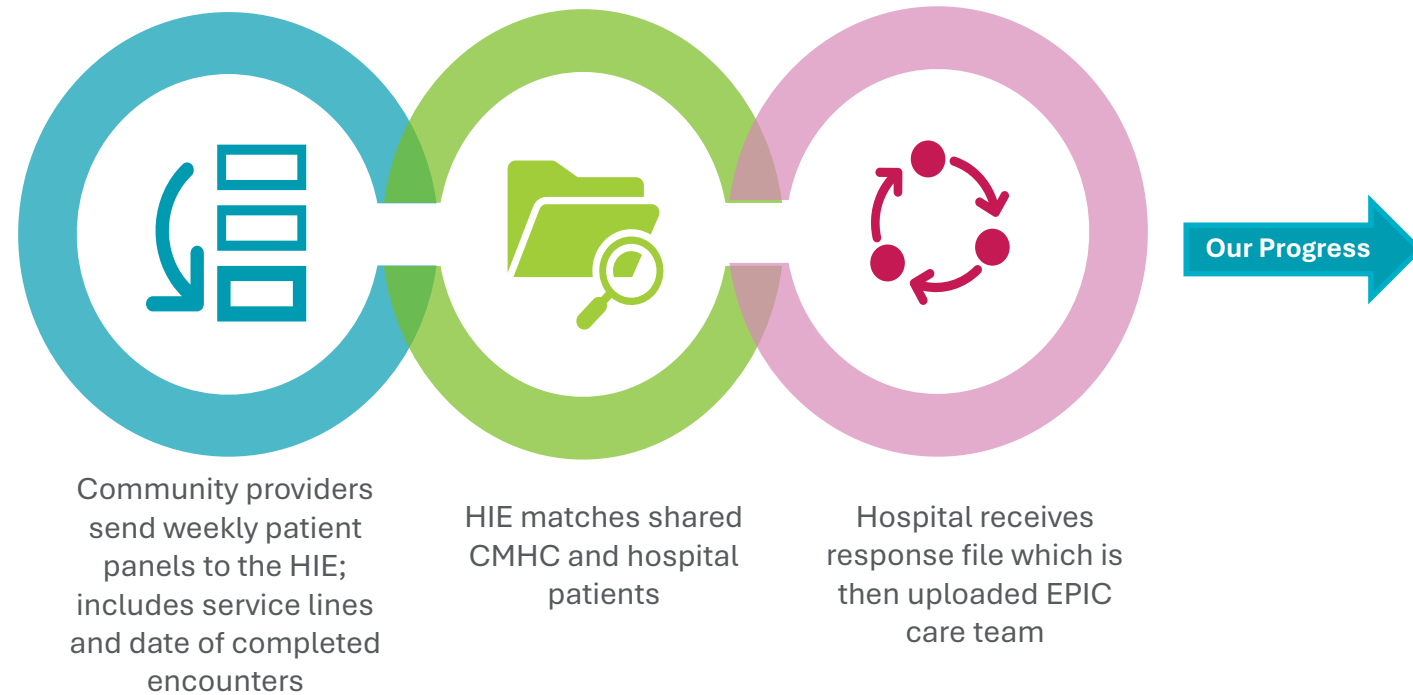
Ability to view patient charts, including visits, admissions, and discharge information

Visibility into patient's care team

“Front Door” to access Healthy Planet

Mental and behavioral health attribution process

Current Workflow Overview



Each week, hospitals and CMHCs are creating real-time lines of sight for shared, active patients.

	Cincinnati Children's	Nationwide Children's
# CMHCs live with attribution	11	3
# matched youth between CMHCs and hospital	~10k	3.5k+
# of community-based services matched patients are receiving	~23k	9k+
# of CMHCs being onboarded to strategy	9	*

Creating visibility of active external mental health services



PROGRAM NAMING CONVENTION

Program abbreviation	Expanded information
BhxSupport/CaseMgmt	Behavioral Support/ Case Management - includes CPST, TBS, Case Management, and Care Coordination
Outpt Therapy	Outpatient Therapy
Intensive Outpt	Intensive Outpatient Therapy, IOP
Day Tx/PHP	Day treatment/Partial Hospitalization Program
Medical Mgmt	Medical Management
Residential	Residential, QRTP, ICF
MobileRespSS	Mobile Response and Stabilization Services
Home-based Tx	Home-based Treatment - Includes Intensive Home-Based Therapy (IHBT), Family-focused therapy (FFT), and Multisystemic Therapy (MST), Assertive Community Treatment (ACT)
ORise CME	OhioRise Intensive Care Coordination, OhioRise Moderate Care Coordination
ORise Aetna CC	OhioRise Limited Care Coordination
BH Respite	Behavioral Health Respite
PRTF	Psychiatric Residential Treatment Facility
Peer Support	Mental Health Certified Peer Supporter – Adult, Family, Youth/Young Adult
Intake	Youth received a DA but not yet enrolled in long-term treatment

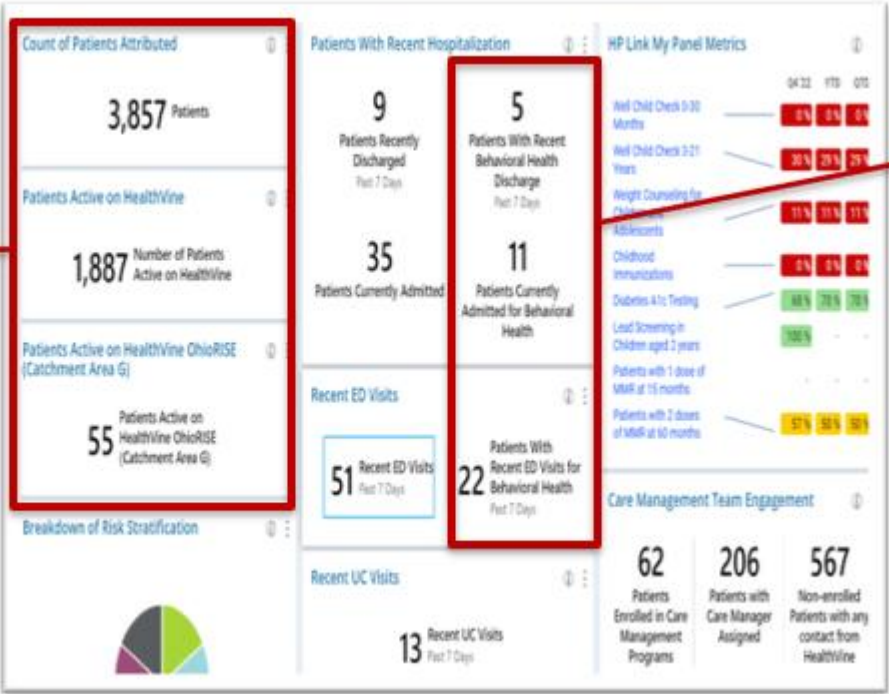
Care Team

- Hplink, Physician, M.D.**
 - PCP - General, PEDIATRICS
 - Added 1 month ago
 - 513-636-2222
- Hplink, Physician, M.D.**
 - PCP - HealthVine PCP
 - Added 10 months ago
 - 513-636-2222
- Healthyplanet, Care Manager**
 - Care Manager RN - Accountable Point of Contact, Managed Care
 - Added 10 months ago
- Hplink, Lighthouse Therapy**
 - Behavioral Health Service, External Behavioral Health
 - Added today
 - 513-487-6705

Attribution strategy is:

- ✓ Active and dynamic
- ✓ Payor agnostic
- ✓ Population health—focused
- ✓ Adaptable for adult care
- ✓ Integrated across primary care and behavioral health
- ✓ Scalable
- ✓ *Concept* is replicable for other non-Epic EHRs

Improving access to timely, clinically actionable information



All matched patients between the hospital and that CMHC

Acute BH utilization

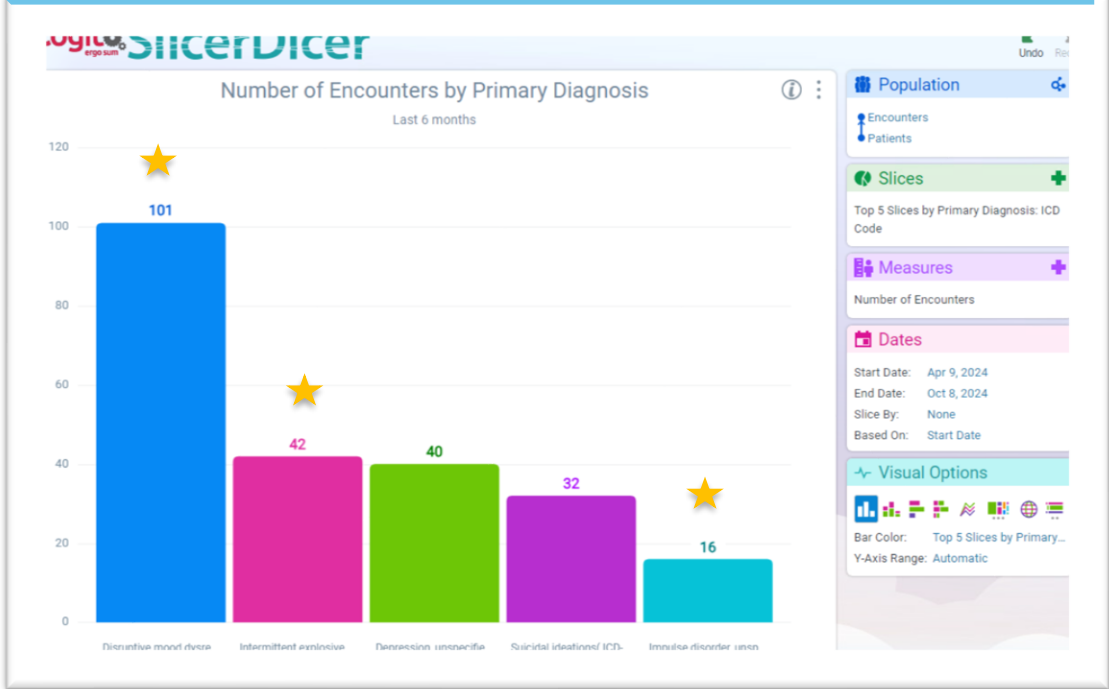
CMHCs organizations have **real-time access** to know when their youth are in the ED or admitted

Providers can identify external treatment team members for **collaboration**.

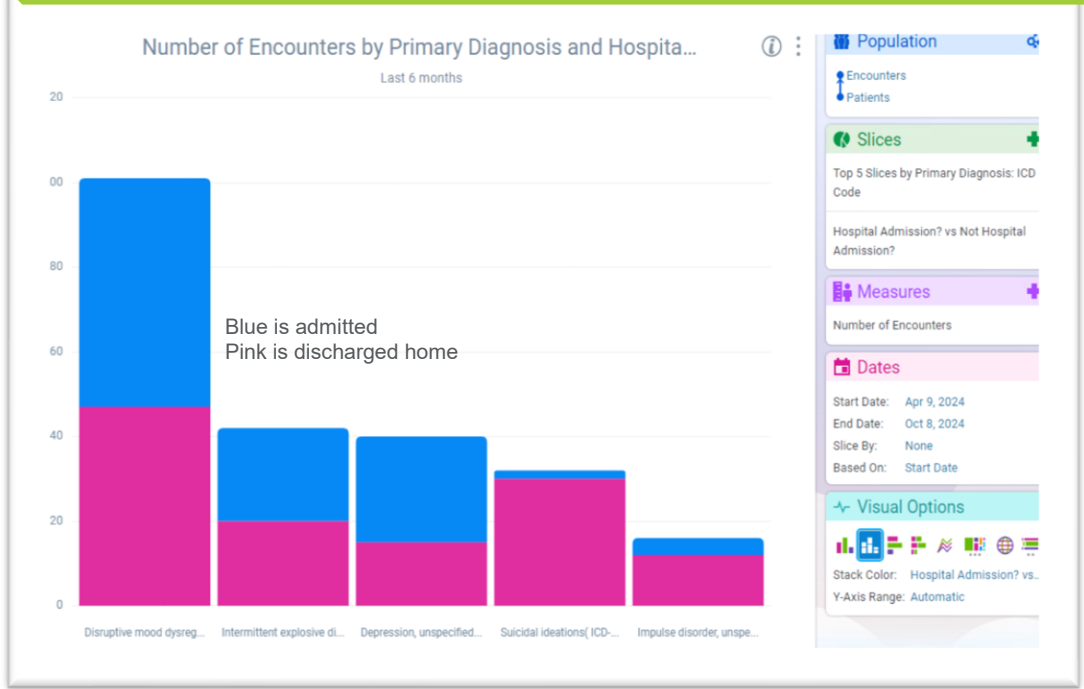
Develop coordinated **Next Best Action** workflows.

Surfaces clinical, social, and utilization patterns

of Encounters by Primary Diagnosis



of Encounters by Primary Diagnosis and Hospital Admission



Care Delivery & Outcomes

- Improves care coordination and continuity
- Enables better clinical decisions with full history
- Enhances crisis response and patient safety
- Supports consistent safety planning
- Drives better long-term outcomes through data

Qualitative data collected through a series of listening sessions with senior leaders from participating CMHCs and Cincinnati Children's moderated by [The Health Collaborative](#)



Workflows & Workforce

- Reduces duplication and workflow inefficiencies
- Improves interoperability and information flow
- Streamlines intake and administrative processes
- Empowers staff with complete data
- Strengthens internal and cross-system collaboration

Qualitative data collected through a series of listening sessions with senior leaders from participating CMHCs and Cincinnati Children's moderated by [The Health Collaborative](#)



Financial Performance

- Lowers cost per patient through reduced duplication
- Avoids high-cost crisis and inpatient utilization
- Improves reimbursement accuracy and value-based performance
- Reduces billing errors and denials
- Increases operational efficiency and margins

Qualitative data collected through a series of listening sessions with senior leaders from participating CMHCs and Cincinnati Children's moderated by [The Health Collaborative](#)



Data & System Transformation

- Enables data-driven quality improvement
- Identifies care gaps and performance opportunities
- Supports attribution and outcome measurement
- Advances behavioral health parity in data systems
- Improves system-wide visibility and coordination

Qualitative data collected through a series of listening sessions with senior leaders from participating CMHCs and Cincinnati Children's moderated by [The Health Collaborative](#)



Using MBH Attribution to Improve Timely Transitions of Care

Timely Follow-Up After ED Encounters Is a Key Ohio Performance Priority

- 1-7 day follow up metrics for mental health (FUM) and substance use disorder (FUA) ED visits part of:
 - State directed payments
 - State learning networks focused on Medicaid populations
 - OAK for pediatrics
 - IMPACT for adults
 - Values-based contracts

A Shared Challenge: Different Entry Points, Same Transition Need

Common Transition Challenges

Both emergency and inpatient pathways share challenges in transitioning patients to community-based behavioral health services effectively.

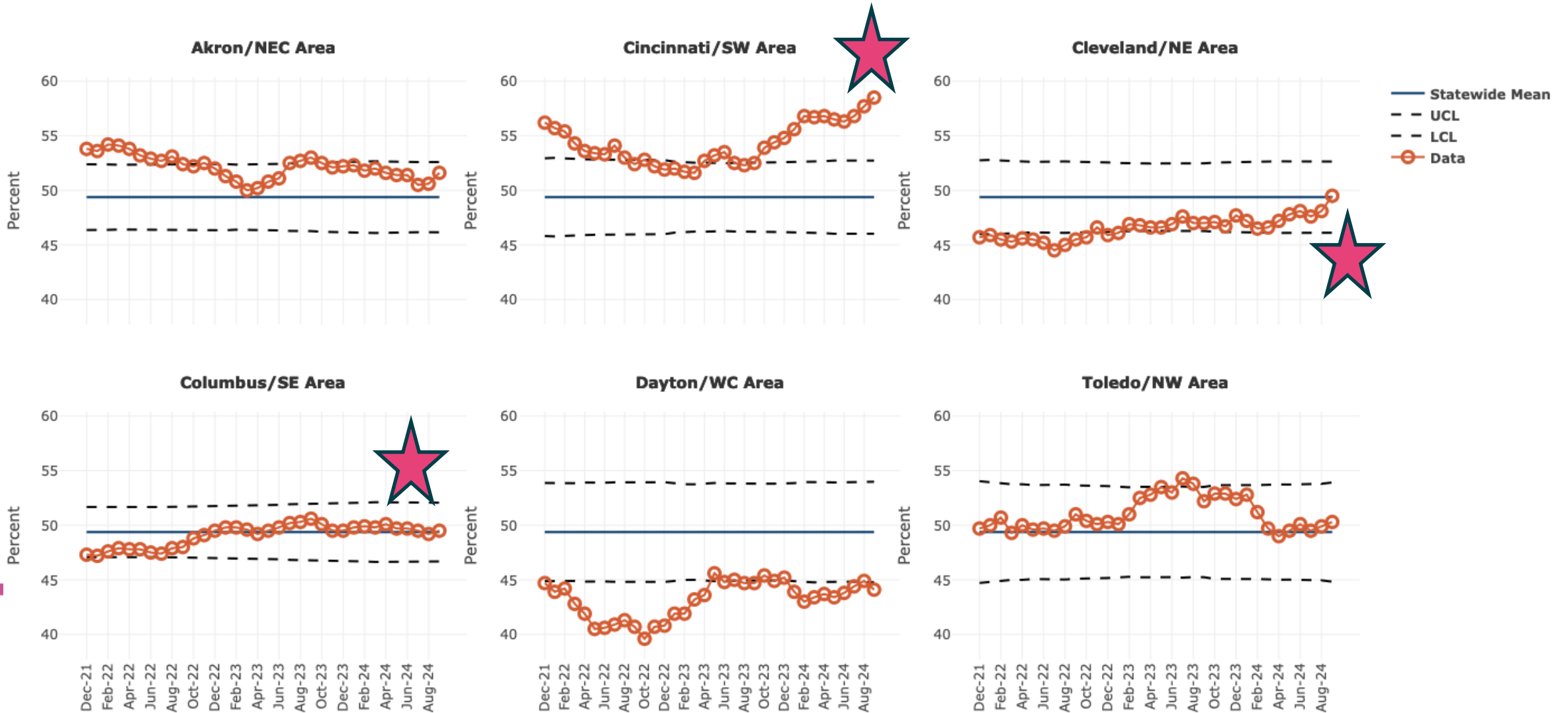
Coordination and Communication Breakdown

Failures often arise from poor communication and lack of visibility between hospital and community providers, impacting follow-up care.

Unified Improvement Framework

Recognizing parallel challenges allows health systems to focus on integration, attribution, and information exchange for better outcomes.

Rational subgrouping by region



Three regions appear to have had shifts in their systems that indicate “special cause”

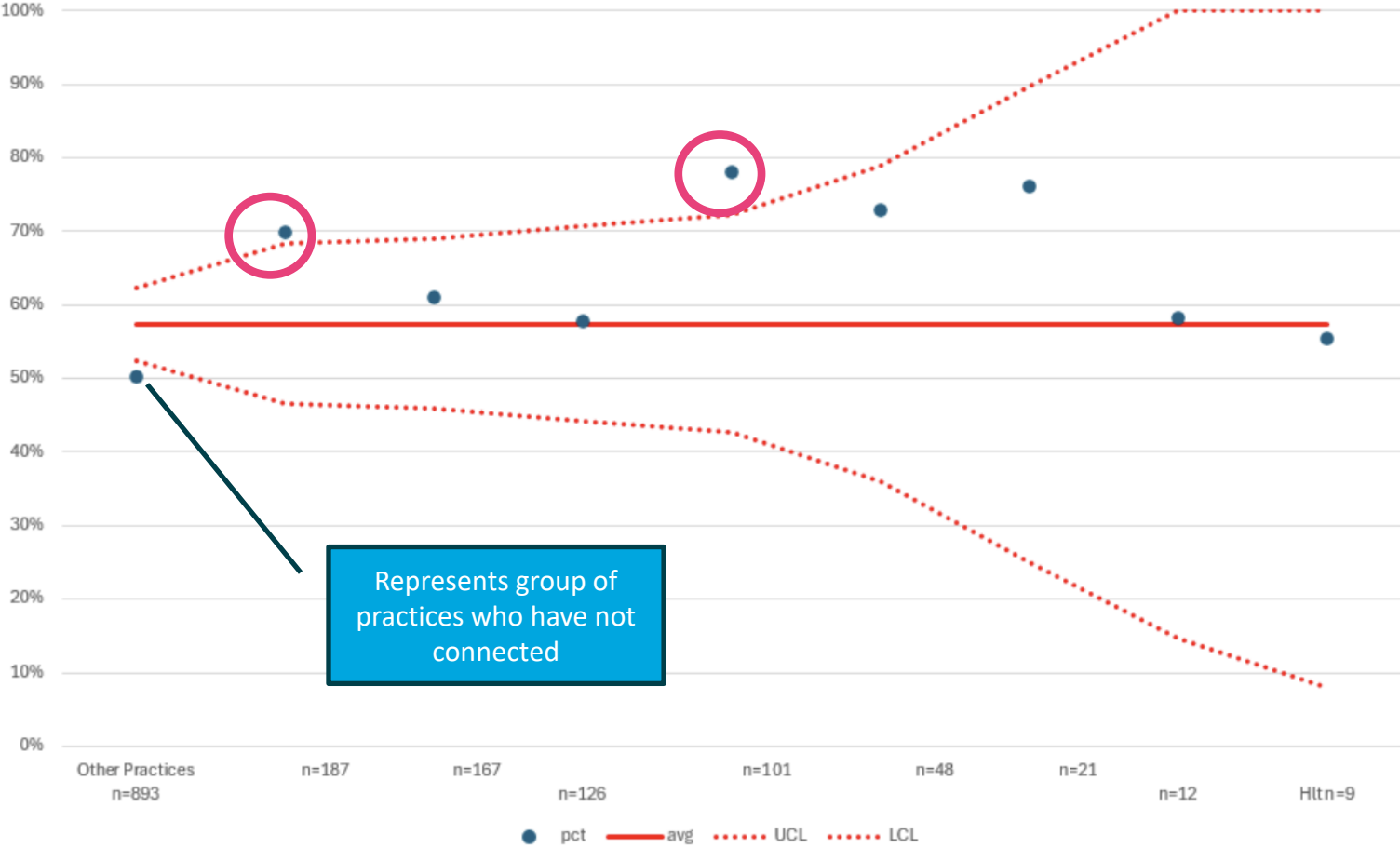
Further drilldown into SW Region: Impact of MBH attribution and BH practice "connection"

* **Highest performers** were early adopters and high-utilizers of the HIE-enabled tools to manage their populations of patients.

* These data would indicate that one significant driver of improved follow up after mental health visits to the ED is connection to a behavioral health organization that is engaged in using these new tools.

MBH attribution selected as a high impact intervention in OAK; actively spreading to the other children's hospital across the state.

OAK Cincinnati/Southwest Area
Follow-up After ED Visit for Mental Health
Connected Practices vs Others
Jan-Sep 2024



Represents group of practices who have not connected

SUMMARY OF INFORMATION FLOW ACROSS SYSTEMS

Community Mental Health Centers (CMHCs)

CMHC patient rosters + program level enrollment

Community providers can look up their patients and obtain clinical information from hospital EHR

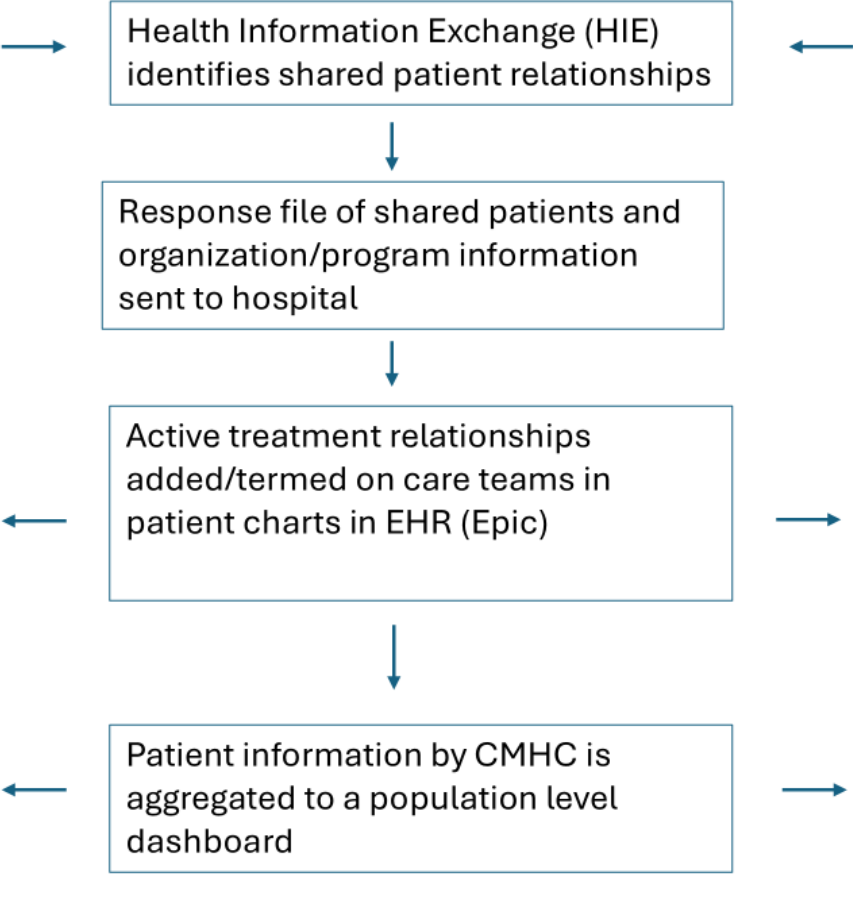
Clinically actionable information easily visible and readily available to support coordination and/or transitions of care

Children's Hospital

Hospital patient roster

Active CMHC treatment relationships visible to anyone in chart for care coordination

Can track utilization of across hospital sites of care in real time and longitudinally



THANK YOU!

Dr. Kate Junger

Katherine.Junger@cchmc.org



Using data sharing information to improve continuity of care

Diane King, Vice President of Quality and Strategy
NewPath Child & Family Solutions

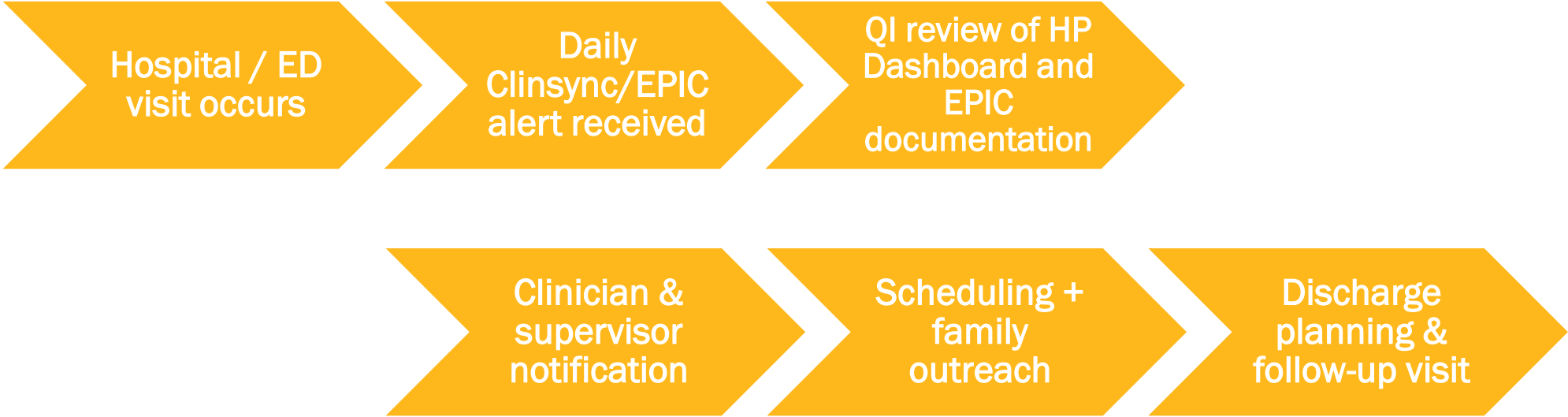


Why is Health Information Exchange (HIE) Important

- Many Behavioral Health Care organizations operate separately from Hospitals, EDs, and PCPs, causing fragmentation in treatment or operating with limited information. HIE participation creates a coordinated care ecosystem.
- Reduces duplication of services.
- Provides access to information, including labs and medication lists, to reduce the likelihood of medication errors.
- *Transforms behavioral health care organizations from reactive and disconnected to coordinated and proactive.*



How information is used to improve care across systems



Strengthening Hospital – Community Partnerships Through Data Sharing

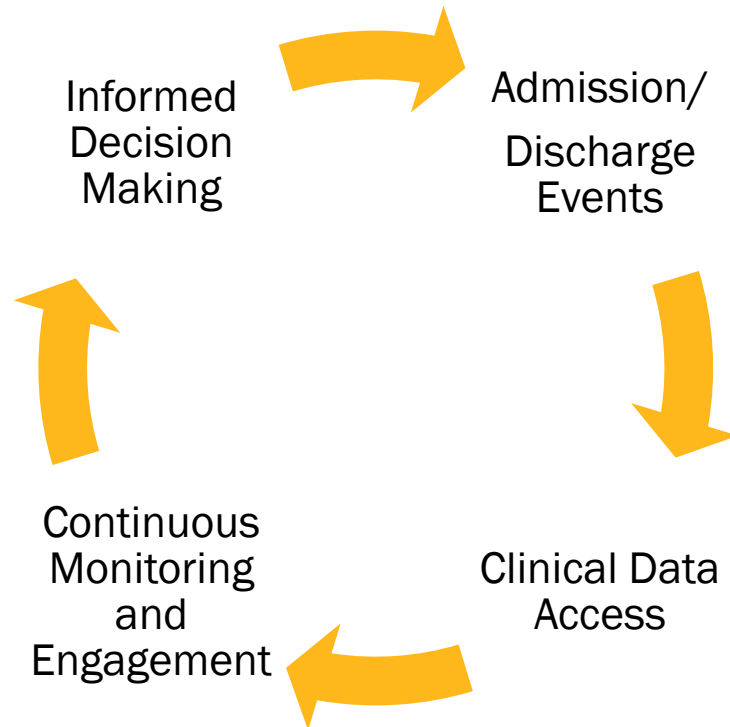
EpicLink access facilitates:

- **Stronger partnerships:** Hospital and Community Agencies are able to work collaboratively to meet the needs of shared patients without duplication of services.
- **Attribution strategy value:** Improved visibility into patient populations so hospitals are able to better understand who they are serving
- **Enhanced clinical access:** Use of EpicLink access has strengthened parity between medical and behavioral health data sharing
- **Healthy Planet Dashboard/Epic Access:** Reduced reliance on admission/discharge/transfer feeds by enabling broader access to clinical information
- **Improved transitions of care:** Continue to build data sharing protocols to continue improvements that have led to faster notifications and stronger provider relationships, moving toward a more



Beyond transitions – Continuous care coordination

Continuous care coordination



Expands beyond ED/IP transitions

- Access to clinical information is not be limited to admission/discharge events
- Continuous data access supports proactive, ongoing care management
- Enables more informed decision-making outside of episodic hospital encounters



Quality Impact

- Building partnerships with the hospitals has provided NewPath the opportunity to participate as a member of a coordinated care ecosystem versus an isolated organization.
 - Creates a holistic care approach for patients
 - Facilitates identification and mitigation strategies for social determinants of health
 - Supports continuity of care or allows for smoother transitions in care, fostering a transfer of trust approach
- Has provided the opportunity to re-connect with disengaged clients and determine their continued need/desire for treatment with NewPath



Quality Impact Continued

- Exceeding national FUH (Follow-up after Hospitalization Mental Health) HEDIS Measure of 45-55% (NCQA). NewPath was able to successfully meet with clients and families within seven days of discharge 78% of the time.
- Exceeding national FUM (Follow-up after ED visit Mental Health) HEDIS Measure of 40-45% (NCQA). NewPath was able to successfully meet with clients and families within seven days of discharge 87% of the time.
- Provides data on the additional supports needed to maintain safely in the community and allows NewPath team to facilitate additional referrals or resources when needed.



Success Stories

- 14 year old male who was hospitalized 10 times in one year. NewPath staffed this case with his treatment team and created a plan to ensure he was at the appropriate level of care and getting the supports needed. Youth has been free from inpatient hospitalization for past 10 months.
- 18 year old female was in the hospital 11 times in one year, three of those hospitalizations within one month. NewPath was able to connect her to appropriate transitional aged services to support her as she transitioned into adulthood. She has been free from inpatient stays for five months.
- 16 year old female living in our semi-independent program was diagnosed with cancer. NewPath was able to connect with Oncology Team at CCHMC to support this young person through her care journey. The CCHMC team was also able to provide training and supports to our Program staff so that they were able to support the young person while in program.



Future Initiatives

- Begin using trend data at the patient level to identify interventions to reduce the number of all cause readmissions.
- Utilize information and partnerships to facilitate closing care gaps to decrease the need for higher levels of care and increase patient satisfaction and outcomes.



The Ohio Health Information Partnership operates CliniSync the Statewide Health Information Exchange

Created in 2009 as an independent 501c(3) non-profit organization

Stakeholder Driven & Funded

Building upon a community of trust to advance the use of data to benefit a person's health and well-being



Founders

Ohio Hospital Association,
Ohio Osteopathic Association,
Ohio State Medical
Association



Board of Directors

Physicians, hospitals,
health plans, long-term
care, consumer group,
FQHCs & behavioral
health



CliniSync Advisory Council

Physicians, hospital systems,
community and children's
hospitals, health plans, long-
term care, behavioral health &
community service
organizations.

THE CLINISYNC COMMUNITY

~ 3B

Clinical Transactions Annually

15M

Persons in the Master Person Index

180

Current or new participating Hospitals in OH, WV, KY

>400

Long-Term and Post-Acute Care Facilities

15,000

Independent and Hospital-employed Physicians

15

Health Plans (8 Medicaid MCOs or MyCare)

100+

Behavioral Health and Social Service Agencies

60

Connected EHRs

MORE

Commercial Lab, Public Health Community Service Organizations and More

OUR VISION IS TO IMPROVE ELECTRONIC COMMUNICATION AMONG THOSE WHO TOUCH A PATIENT'S CARE SO WE CAN IMPROVE HEALTH CARE FOR ALL OHIOANS



Ohio Health Information Partnership
Health Information in a Heartbeat

Username

Password

LOG IN

[Reset Password](#)
[Username is required](#)

CliniSync is a health information exchange application, developed and sponsored by the Ohio Health Information Partnership. CliniSync provides secure, encrypted access to confidential patient information. Only authorized users are permitted to access this application. Under federal HIPAA regulations, it is a criminal offense to disclose or misuse patient healthcare data.



For login assistance, please call CliniSync Support at 1-800-645-8192.

The vision is for information to be wrapped around the person.



Behavioral Health Implementations

Ohio Statewide Behavioral Health Attribution and Data Project

In coordination with Pediatric and Ohio Health Systems, Health Plans and Behavioral Health Providers across Ohio, CliniSync is launching a new Behavioral Health Attribution and Data Project.

This effort will allow better treatment coordination across healthcare agencies for those Ohioans in need.

Follow the steps below if you are interested in participating and are a provider caring for patients with Behavioral Health needs:

- [Click here to enter your contact information](#)
 - CliniSync will email you once your request is processed.
 - In the reason for the inquiry field, please indicate you are interested in signing up for the Behavioral Health Attribution Project, which organization referred them to CliniSync and the CliniSync services they are interested in.
 - Links for both [Notify](#) and the [Community Health Record](#).
 - If you are not contracted with CliniSync, please download and sign a copy of the Participation and Business Association Agreement with CliniSync, available [here](#)
 - Review and send an executed copy to Phil Ennen at pennen@ohip.org.

If you are a Behavioral Health treating entity and are not yet contributing data to CliniSync, you can download the specification file [here](#)

- CliniSync will follow up based upon the information included when you Sign up for Services.

These efforts are offered at **no additional cost**

Below are organizations that are live with data contribution:

CURRENT PROCESS

- Weekly files
- The files contain:
 - Patient Demographics
 - Community Behavioral Organization
 - Program Patient is Enrolled In
 - Last Date Seen
 - Provider Name & NPI
- Files are converted to a clinical encounter
 - Generate Notifications
 - Create a record in the longitudinal patient chart

```
return this.each(function() { var  
(b));c.VERSION="3.3.7",c.TRANSITION_  
(d=b.attr("href"),d=d&&d.replace(/.*(  
dTarget:b[0]}),g=a.Event("show.bs.tab",{  
ivate(b.closest("li"),c),this.activate(h,  
Target:e[0]}))}}},c.prototype.activate=fun  
)end().find('[data-toggle="tab"]').attr("ar  
width,b.addClass("in"):b.removeClass("fade"),  
attr("aria-expanded",!0),e&&e()}var g=d.find("  
);g.length&&h?g.one("bsTransitionEnd",f).emul  
.tab.Constructor=c,a.fn.tab.noConflict=functi  
bs.tab.data-api",[data-toggle="tab"],e).on(  
this.each(function(){var d=a(this),e=d.data(  
ion(b,d){this.options=a.extend({},c.DEFAULTS,  
is)).on("click.bs.affix.data-api",a.proxy(th  
checkPosition());c.VERSION="3.3.7",c.RESET  
is.$target.scrollTop(),f=this.$element.off  
!=c?!(e+this.unpin<=f.top)&&"bottom":!(e+  
"bottom"},c.prototype.getPinnedOffset=f  
target.scrollTop(),b=this.$element.o  
xy(this.checkPosition,this) 1))  
f=d.bottom
```



2027

Implementation of a
CFR 42; Part 2
compliant section of
CliniSync

BH PART 2 SUBCOMMITTEE

Developed:

- STANDARDIZED LANGUAGE FOR CONSENT TO SHARE PART 2 PROGRAM (SUBSTANCE USE DISORDER PROVIDER) INFORMATION
- MODEL NPP LANGUAGE FOR PATIENT NOTICE

WORKFLOW FOR MOVEMENT OF 42 CFR PART 2 DATA UNDER THE PART 2 FINAL RULE

Consent Process for SUD Treatment Facility

- Patient receives a Part 2 Patient Notice & signs Part 2 consent form.

Transmission of Data Disclosure and Redisclosure

- Part 2 data is submitted to CliniSync & the “Notice to Accompany Disclosure”** will be part of the consent language.
- Data is shared through CHR with other treating providers.

Revocation of Consent


- Patient revokes consent & Part 2 program notifies the HIE, the patient is Opted Out.
- Part 2 data cannot be redisclosed once consent has been revoked & any CE or BA must cease using or disclosing data.

****Final rule requires that “Each disclosure made with the patient's written consent must be accompanied by a copy of the consent or a clear explanation of the scope of the consent provided.”**

VIEW ONLY ACCESS WITH SSO OPTIONS

**OUR VISION IS TO IMPROVE ELECTRONIC COMMUNICATION
AMONG THOSE WHO TOUCH A PATIENT'S CARE SO WE CAN
IMPROVE HEALTH CARE FOR ALL OHIOANS**

CliniSync is a health information exchange application, developed and sponsored by the Ohio Health Information Partnership. CliniSync provides secure, encrypted access to confidential patient information. Only authorized users are permitted to access this application. Under federal HIPAA regulations, it is a criminal offense to disclose or misuse patient healthcare data.



Ohio Health Information Partnership
Health Information in a Heartbeat

Username

Password

LOG IN

[Reset Password](#)
Username is required

For login assistance, please call CliniSync Support at 1-800-645-8192.