Section 1115 (a) Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Demonstration:
Instructions for Completing the Template for SMI/SED Health Information Technology (IT) Plan

This section provides guidance on how states can complete Section 6 of the HIT Plan of the SMI/SED Implementation Plan. The following guidance is presented in two parts: 1) guidance for completing statements of assurance and 2) instructions and guidance for completing Table 1.

If the state is pursuing a concurrent SUD/SMI/SED demonstration, this template should be an amendment to the existing SUD health IT plan template.

Part 1: Guidance for Completing Statements of Assurance

Please review each statement of assurance below. Below each statement are key topics for the state to consider while drafting their response.

Statement 1: Indicate whether the state has sufficient health IT infrastructure/ "ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration.

- The state should clearly define what they consider as "sufficient" based on the goals of their demonstration.
- Based on this analysis, if the state finds that sufficient health IT infrastructure is not in place, please indicate the timeframe, milestones and entity responsible for completion.

Statement 2: Indicate whether the state's SMI/SED Health IT Plan is "aligned with the state's broader State Medicaid Health IT Plan (SMHP) and if applicable, the state's Behavioral Health (BH) Health IT Plan" and the Substance Use Disorder/Opioid Use Disorder Health IT Plan.

- If the statement reflects that plans have not yet been aligned, please indicate the timeframe for beginning these discussions and a process to ensure that the state will harmonize with all the other relevant health IT plans in the state.

Statement 3: Indicate that the state will include appropriate standards referenced in the ONC Interoperability Standards Advisory (ISA) (https://www.healthit.gov/isa/) and 45 CFR 170 Subpart B in subsequent MCO contract amendments or Medicaid funded MCO/ Health Care Plan re-procurements.

- Some relevant examples of specific health IT standards referenced in the ISA are:
    - Electronic Prescribing – A Prescriber's Ability to Obtain a Patient's Medication History from a Prescription Drug Monitoring Program (Section II-I)
    - "Direct" transport standards
    - Documenting and Sharing Care Plans- Care Plan standards (HL7 C-CDA R2.1)
    - Sending a Notification of a Patient's Admission, Discharge and/or Transfer Status to Other Providers - ADT Alerting and Messaging
    - Clinical Quality Measurement and Reporting

- Identity management - Patient demographic record matching (chapter 3), exchanging patient identification management within a community (see section 2.5.1)

Part 2: Instructions and Guidance for Completing Table 1

1. Please review Table 1 with the 7 sections containing 15 milestone criteria located on page 13-14 of the SMI 1115 Implementation Plan:

Description of Health IT Functionality	Current State	Future State	Summary of Actions Needed
	Describe the current state of the health IT functionalities outlined below:	Describe the future state of the health IT functionalities outlined below:	Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:
Closed Loop Referrals and e-Referrals (Section 1)			
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider			
1.2 Closed loop referrals and e-referrals from			

2. In each row (milestone criteria), under the second column, *Current State*, enter a response on how the state is currently using state health IT functionality to meet the milestone.
3. In each row (milestone criteria), under the third column, *Future State*, enter a response and describe the future state of the health IT functionality to meet the milestone.
    a. The responses for each row under column 3, should build on the gaps identified in the responses included for that row in column 2. The state should indicate what the envisioned health IT functionality is for the state with respect to each milestone.
    b. For example, in Criterion 1, should the state indicate there is no or minimal activity to link PDMPs to state health IT systems, then the response for row 2, column 3, should indicate what the PDMP integration end-state goal is for the state. This could be, for example, to integrate the PDMP to one of the state's HIEs or to link PDMP to all pharmacy health IT systems.
4. In each row (milestone criteria), under the fourth column, *Summary of Actions Needed*, enter a response and describe the summary of actions needed to meet the future state of health IT functionality.
    a. Enter a response listing actions the state needs to take to move from current state activities to future state capability.
        i. If the state does not have actual strategies mapped out, please include a plan with responsible parties and milestones and timeframes to develop and implement the strategy.
    b. Indicate the process or the entity that will complete the action. This could be an individual or department as long as the role is understood (e.g. Division of Community Health).

c. If no action is necessary, indicate as such. Where actions are required from the state, provide additional detail. Examples of key questions to answer in this section include:
    i. Which department/person is responsible for executing this?
    ii. What are the milestones and general timeframes for accomplishing this?
d. The STCs require the state to "include in its monitoring plan an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or state defined metrics to be approved in advance by CMS."
    i. To support monitoring of the actions, include draft measures (process and outcome).
    ii. List the department/person responsible for monitoring.

Additional Guidance and Resources

Please find below additional guidance and resources for each of the 7 sections.

Section 1: Closed Loop Referrals and e-Referrals

Referrals involve PCPs generating a consultation request and transferring relevant information to other health care providers, such as specialists. In an ideal scenario, the specialist "closes the loop," by responding to the primary care physician with a consultation summary, which provides details about findings and the episode of care. This process serves as a foundation of care coordination and is essential to helping providers deliver more efficient and effective health care.[i] Closed loop referrals and e-referrals are critical in implementing strategies for effective care coordination and discharge planning.

There are multiple health IT standards states can use to advance e-referrals and closed loop referrals from the fully mature HL7 (CDA®), Release 2.0, Final Edition, with wide scale adoption levels to the emerging implementation specification balloted draft closed loop referral standard in the IHE Patient Care Coordination Technical Framework Supplement 360 Exchange Closed Loop Referral (360X) Rev. 1.1 – Trial Implementation.

For relevant health IT standards, please refer to the ONC Interoperability Standards Advisory: https://www.healthit.gov/isa/support-a-transition-care-or-referral-another-health-care-provider

Resources:

- Behavioral Health Integration: Health IT Considerations. https://www.healthit.gov/sites/default/files/onc_sim_resource_center_webinar032916.pdf
- Behavioral Health Data Exchange/ Primary Care and Behavioral Health Integration. https://www.healthit.gov/topic/health-it-initiatives/behavioral-health-data-exchange-primary-care-and-behavioral-health
- Using Health IT to Integrate Behavioral Health and Primary Care Information. https://www.healthit.gov/buzz-blog/health-innovation/health-integrate-behavioral-health-primary-care-information

- Interoperability Proving Ground (IPG) submissions within the ONC Tech Lab are submitted by healthcare, technology and development organizations that are invested in Health IT and Interoperability and want to share, learn and collaborate with similar stakeholders in the US, and around the world. https://www.healthit.gov/techlab/ipg/node/4/submission/1416
- Behavioral health and health IT. https://www.healthit.gov/sites/default/files/bhandhit_issue_brief.pdf
- National Association of Community Health Centers (NACHC) Behavioral health Integration and Data Exchange: Privacy and Exchange Considerations for Community Health Centers, September 2016. http://www.corhio.org/library/documents/PDF_Collateral/BehavioralHealthIntegrationandDataExchange.pdf
- Reliance eHealth Collaborative (Oregon) – Transforming Behavioral Health Care in Oregon Through Information Technology Forum, Best Practices, Challenges, and Lessons Learned July 25, 2017. Includes a presentation on integrating BH and physical health information, a FAQ on BH information exchange, and a BH exchange legal analysis report (HIPAA and 42 CFR Part 2), and a BH use case matrix (variations on a theme of information sharing). http://reliancehie.org/behavioralhealthforum/
- Health Current HIE Success Stories (Use Cases): https://healthcurrent.org/hie-participants/hie-success-stories/

Criterion for Section 1 referenced below:

- Criterion 1.1: Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider.
- Criterion 1.2: Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider.
- Criterion 1.3: Closed loop referrals and e-referrals from physician/mental health provider to community based supports.

Section 2: Electronic Care Plans and Medical Records

Electronic Care Plans

A shared care plan is a patient-centered health record designed to facilitate communication among members of the care team, including the patient and providers. Rather than relying on separate medical and behavioral health care (treatment) plans, a shared plan of care combines both aspects to encourage a team approach to care. It is helpful to have a patient's shared care plan linked with the electronic health record (EHR) system when feasible. Many elements of the care plan can then be populated automatically with information from the EHR.[ii]

There are several health IT standards states can use to share electronic care plans and health records for a single clinical context from the implementation specification balloted draft HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Release 2.1 to the emerging implementation specification balloted draft HL7 Resource Care Plan (v3.0.1). For multiple clinical contexts or sharing care planning for multiple clinical contexts with a patient care team, there are two health IT standards from the emerging implementation specification balloted draft IHE Dynamic Care Planning (DCP), Rev 1.2 Trial Implementation to the emerging implementation specification balloted draft IHE Dynamic Care Team Management (DCTM), Rev 1.1 Trial Implementation.

For relevant health IT standards, please refer to the ONC Interoperability Standards Advisory: https://www.healthit.gov/isa/support-a-transition-care-or-referral-another-health-care-provider

Transitions of Care

The Centers for Medicare & Medicaid Services (CMS) defines a transition of care as the movement of a patient from one setting of care to another. Settings of care may include hospitals, ambulatory primary care practices, ambulatory specialty care practices, long-term care facilities, home health, and rehabilitation facilities.

Transitions increase the risk of adverse events due to the potential for miscommunication as responsibility is given to new parties. Hospital discharge is a complex process representing a time of significant vulnerability for patients. Safe and effective transfer of responsibility for a patient's medical care relies on effective provider communication with patient comprehension of discharge instructions (Gallahue, et al., 2015). [iii]

There are several health IT standards states can use for transitions of care from the fully mature HL7 (CDA®), Release 2.0, Final Edition, with wide scale adoption levels to the emerging implementation specification balloted draft closed loop referral standard in the IHE Patient Care Coordination Technical Framework Supplement 360 Exchange Closed Loop Referral (360X) Rev. 1.1 – Trial Implementation.

For relevant health IT standards, please refer to the ONC Interoperability Standards Advisory: https://www.healthit.gov/isa/support-a-transition-care-or-referral-another-health-care-provider

Resources:

- Massachusetts eHealth Institute – use cases for care coordination. https://mehi.masstech.org/education/resources-tools/hie-toolkit/use-case-library
- MiHIN (Michigan Health Information Network Shared Services) Use Case Factory – Care Coordination topic: https://mihin.org/care-coordination/
- HIMSS Interoperability Maturity Model Task Force, Use Case 5: Query HIE for Medical History. https://www.himss.org/use-case-5-query-hie-medical-history (See all six of the Interoperability Use Cases: https://www.himss.org/library/interoperability-standards/adoption-implementation/use-cases
- This 2016 report provides an overview of data from the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances program. It presents findings that indicate that systems of care provide services and promote positive outcomes for underserved children and youth within the mental health system. https://store.samhsa.gov/product/The-Comprehensive-Community-Mental-Health-Services-for-Children-with-Serious-Emotional-Disturbances/PEP18-CMHI2016
- This report provides an overview of data from the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances program. It presents findings that indicate that systems of care provide services and promote positive outcomes for underserved children and youth within the mental health system. https://store.samhsa.gov/product/2015-Report-to-Congress-for-the-Evaluation-of-the-Comprehensive-Community-Mental-Health-Services-for-Children-with-Serious-Emotional-Disturbances/PEP16-CMHI2015
- Engaging Behavioral Health Providers through HIE to Improve Healthcare Delivery and Outcomes in Arkansas. https://www.healthit.gov/sites/default/files/arkansasbh_brightspot8-16-16.pdf
- Expanding Health Information Exchange for Mental Health Providers in South Carolina. https://www.healthit.gov/sites/default/files/sc_brightspot_08022016.pdf
- AHRQ – Agency for Healthcare Research and Quality Care Coordination measures Atlas Update (June, 2014). https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/index.html
- AHRQ – Agency for Healthcare Research and Quality Care Coordination measures Atlas Update (June, 2014). https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/index.html
- Expanding Health Information Exchange for Mental Health Providers in South Carolina. https://www.healthit.gov/sites/default/files/sc_brightspot_08022016.pdf

Criterion for Section 2 referenced below:

- Criterion 2.1: The state and its providers can create and use an electronic care plan.
- Criterion 2.2: E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers.
- Criterion 2.3: Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications.

- Criterion 2.4: Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications.
- Criterion 2.5: Transitions of care and other community supports are accessed and supported through electronic communications.

Section 3: Consent - E-Consent (42 CFR Part 2/HIPAA)

As Electronic health information exchange (eHIE) increases, patient trust must be ensured and patients may more frequently be asked to make a "consent decision." This consent decision concerns the sharing and accessing of the patient's health information for treatment, payment, and health care operations purposes. Consent should not be a "check-the-box" exercise. Meaningful consent occurs when the patient makes an informed decision and the choice is properly recorded and maintained.[iv]

There are several health IT standards states can use for consent from the fully mature IHE Basic Patient Privacy Consents (BPPC) and the emerging implementation specification HL7 Implementation Guide for CDA®, Release 2: Consent Directives, Release 1, to the emerging implementation specification IHE Advanced Patient Privacy and Consents (APPC), and the emerging standard HL7 FHIR® Contract Resource.

For relevant health IT standards, please refer to the ONC Interoperability Standards Advisory: https://www.healthit.gov/isa/support-a-transition-care-or-referral-another-health-care-provider

Resources:

- Permitted Uses and Disclosures: Exchange for Health Care Operations https://www.healthit.gov/sites/default/files/exchange_health_care_ops.pdf
- Permitted Uses and Disclosures: Exchange for Treatment https://www.healthit.gov/sites/default/files/exchange_treatment.pdf
- Patient Consent for Electronic Health Information Exchange and Interoperability. https://www.healthit.gov/topic/interoperability/patient-consent-electronic-health-information-exchange-and-interoperability
- HHS: Information Related to Mental and Behavioral Health, including Opioid Overdose. This page has over a dozen links to (mostly) PDFs related to HIPAA and various aspects of care coordination and information sharing for people with mental illness. As stated: "This page is intended to be a one-stop resource for guidance and other materials on how HIPAA applies to mental health and substance use disorder information. It will be periodically updated with additional information." https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html
- Behavioral Health Clinical Quality Measures https://www.healthit.gov/topic/behavioral-health-clinical-quality-measures

Criterion for Section 3 referenced below:

- Criterion 3.1: Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties.

Section 4: Interoperability in Assessment Data

Data collected from an intake, assessment or screening tool is critical information to the effective evaluation and treatment of an individual. These tools can cover anything from medical conditions to social and developmental history, to observations across settings to assess functional and behavioral skills to mood questionnaires. To support effective care coordination of services as well as provide timely treatment to patients who may have discontinued engagement or have stopped engagement in their treatment, it's paramount that all providers on the patient's care team have timely and appropriate access to this information across systems.

Resources:

- This guide helps local systems use data to implement Crisis Intervention Team programs that can improve the safety and effectiveness of law enforcement response to people experiencing behavioral health crises. It provides information about building necessary partnerships, documenting program activities, identifying key metrics, establishing data collection processes, analyzing and reporting data, using data to improve programs, and expanding capacity to collect and use data. The guide is a companion to Practice Guidelines: Core Elements in Responding to Mental Health Crises (SMA09-4427). https://store.samhsa.gov/product/Crisis-Intervention-Team-CIT-Methods-for-Using-Data-to-Inform-Practice-/sma18-5065

Criterion for Section 4 referenced below:

- Criterion 4.1: Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem.

Section 5: Electronic Office Visits – Telehealth

Telehealth refers to the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health related education, public health, and health administration.[1] Health information exchanged may be in the form of multiple formats: text, graphics, still images, audio, video and terrestrial and wireless communications. Each of these can be exchanged using one of four basic methods:

- **Live video (synchronous)**: live, 2-way interaction between a beneficiary and a provider using audiovisual telecommunications technology
- **Store-and-forward (SFT) (asynchronous)**: The secure transmission of videos and digital images after they have been captured (e.g. x-rays send from referring physician to another provider).

[1] https://www.healthit.gov/playbook/patient-engagement/#section-5-3

- **Remote patient monitoring (RPM):** The collection of personal health and medical data in one location for submission to a provider in another location (e.g. Holter monitors for capturing and sharing vital statistics).
- **Mobile or digital health**: the use of smartphone apps to foster health and well-being.

Through these methods, telehealth plays a significant role in supporting care coordination and beneficiary engagement by allowing providers to communicate with beneficiaries outside of the traditional clinical setting. Methods such as RPM and mobile health allow providers to directly engage with beneficiaries to track and manage acute and chronic conditions.

States have significant variability in their telehealth reimbursement laws and Medicaid policies. However, there is an opportunity to design and structure their telehealth models to support health information exchange.

Resources:

- Telemedicine and telehealth. https://www.healthit.gov/topic/health-it-initiatives/telemedicine-and-telehealth
- The Role of Telehealth in an Evolving Health Care Environment is a FORHP-commissioned report from the Institutes of Medicine on how telehealth technology can fit into the U.S. health care system.

Criterion for Section 5 referenced below:

- Criterion 5.1: Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care.

Section 6: Alerting/Analytics (Clinical Decision Support)

The term "alerting" and "analytics" can be used in many contexts. In one context, "alerting" can refer to event notifications which notify providers in real-time when a patient has an encounter at another facility. Typically, providers involved in a patient's care will receive an alert for an admit, discharge or transfer (ADT) along with additional information such as updated patient demographics. "Alerting" can also refer to an alert generated within the provider's electronic health record. These alerts, also referred to as a type of clinical decision support tool, provide clinicians, staff, patients or other individuals with knowledge and person-specific information, intelligently filtered or presented at appropriate times, to enhance health and health care.

Overall, clinical decision support encompasses a variety of tools to enhance decision-making in the clinical workflow. These tools not only include computerized alerts and reminders to care providers and patients, but also clinical guidelines, condition-specific order sets, focused patient data reports and summaries, documentation templates, diagnostic support, and contextually relevant reference information, among others.

Resources:

Aligning Health IT Implementation with Delivery System Transformation Clinical Alerting and Event Notifications (ADT Alerting)
https://www.healthit.gov/sites/default/files/simergyhealthit_learning_cluster12715.pdf

Criterion for Section 6 referenced below:

- Criterion 6.1: The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes.
- Criterion 6.2: Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis.

Section 7: Identity Management

Identity management includes all activities related to establishing, verifying, managing and linking the identity of individuals in order to approve their access to a particular system or to link an individual to their digitized information (e.g., entry to a physical building, access to a company network) with and across systems. In the context of health care, identity management can be used to:

- Control access to health-related information and meet regulatory requirements.
- Link health information with the correct individual.
- Link health outcomes with providers, organizations, and care teams.

Data identity management requires that all users be identified and authenticated for system access to ensure participants cannot fraudulently pose as another user. To learn more about Identity Management across the healthcare ecosystem, refer to the Identity Management Implementation Guide.

Resources:

- Master Patient Index (MPI) tools are used to establish and verify the identity of a patient in order to approve their access to a particular system or information. This linking of patient data is referred to as patient matching. To learn more about the role of MPIs in health information exchange, refer to the ONC Report on "Master Data Management in HIE Infrastructures":
  https://www.healthit.gov/sites/default/files/master_data_management_final.pdf

- The Office of the National Coordinator for Health IT (ONC) Identity Management Implementation Guide defines identity management as a core health IT function needed for privacy and security, care coordination, service delivery, value-based payment (VBP), and performance measurement. Identity Management includes managing digital identities and linkages across an individual patient, and managing access to these identities by authorized health care providers, family members, caregivers, and other stakeholders.

https://www.healthit.gov/sites/default/files/identitymanagementguidev5.13.pdf

Criterion for Section 7 referenced below:

- Criterion 7.1: As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records.
- Criterion 7.2: Electronic medical records capture all episodes of care, and are linked to the correct patient.

---

[i] https://www.healthit.gov/sites/default/files/bright-spots-synthesis_care-coordination-part-i_final_012813.pdf
[ii] https://integrationacademy.ahrq.gov/products/playbook/develop-shared-care-plan
[iii] https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure1.html
[iv] https://www.healthit.gov/topic/meaningful-consent-overview

PRA Disclosure Statement *This information is being collected to assist the Centers for Medicare & Medicaid Services in program monitoring of Medicaid Section 1115 Severe Mental Illness and Severe Emotional Disturbance Demonstrations. This mandatory information collection (42 CFR § 431.428) will be used to support more efficient, timely and accurate review of states' monitoring report submissions of Medicaid Section 1115 Severe Mental Illness and Severe Emotional Disturbance Demonstrations, and also support consistency in monitoring and evaluation, increase in reporting accuracy, and reduction in timeframes required for monitoring and evaluation. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.*

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #59). The time required to complete this information collection is estimated to average 29 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.