

# LAKE COUNTY MENTAL HEALTH COALITION

## Data Sharing Project Report

December 11, 2017

# TABLE OF CONTENTS

- 1. EXECUTIVE SUMMARY .....5**
  
- 2. DATA SHARING PROJECT OVERVIEW AND APPROACH .....17**
  - 2.1 Lake County Mental Health Coalition Overview ..... 18
  - 2.2 Data Sharing Project Purpose..... 22
  - 2.3 Data Sharing Project Approach ..... 27
    - 2.3.1 Visioning Session..... 29
    - 2.3.2 Research Approach ..... 30
    - 2.3.3 Current Data Sharing Assessment Approach ..... 33
    - 2.3.4 Facilitated Discussions Approach ..... 35
  
- 3. RESEARCH CONDUCTED.....38**
  - 3.1 Research Review..... 40
    - 3.1.1 Prior Reports/Evaluation of Lake County Initiatives ..... 41
    - 3.1.2 National and Local Trends Impacting Behavioral Health ..... 51
    - 3.1.3 Comparable Data Sharing Models from Other Communities ..... 58
    - 3.1.4 Theoretical Models ..... 95
    - 3.1.5 Data Governance Approaches ..... 113
    - 3.1.6 Data Sharing Agreements ..... 124
    - 3.1.7 Laws Impacting Sharing Of Data In Lake County ..... 128
    - 3.1.8 Data Privacy Practices..... 133

# TABLE OF CONTENTS

- 3.2 Current Data Sharing Assessment .....137**
  - 3.2.1 Introduction to the Current Data Sharing Assessment.....138
  - 3.2.2 Sector Analysis from Interviews .....141
    - 3.2.2.1 Healthcare Organizations .....142
    - 3.2.2.2 Justice System .....148
    - 3.2.2.3 Community organizations.....155
  - 3.2.3 Current Data Sharing Technology .....160
  - 3.2.4 Current Data Sharing Availability and Existing Partnerships .....165
  - 3.2.5 Barriers to Data Sharing .....179
  - 3.2.6 Legal Considerations to Data Sharing .....188
  - 3.2.7 Change Management Status.. .....192
  
- 3.3 Facilitated Discussions with Lake County Mental Health Coalition.....194**
  
- 4. DATA SHARING PROJECT FINDINGS.....200**
  
- 5. DATA SHARING VISION AND DATA SHARING PROJECT RECOMMENDATIONS.....213**
  - 5.1 Data Sharing Vision.....214
  - 5.2 Recommendations .....218
  
- 6. COALITION PREFERRED ACTION PLAN AND GO FIRST STRATEGIES .....260**

# TABLE OF CONTENTS

## 7. APPENDICES

7.1. Lake County Mental Health Coalition Charter

7.2 Glossary of Terms

7.3 Current Data Sharing Assessment Interviewee List

7.4 Current Data Sharing Assessment Interview Guide

7.5 Excerpts from the Illinois HHS Medicaid Waiver Advisory Committee Discussion

7.6 Public Awareness Campaign Socialization

7.7 Example Data Sharing Agreements

7.8 Barriers to Data Sharing

7.9 Poll Everywhere Results June Meeting Results

7.10 Data Matrix – Extended List of Data / Measures

7.11 Data Matrix – Abbreviated List of Data / Measures

7.12 Systemic Questions to Prioritize Workshop 1

7.13 Systemic Questions to Prioritize Workshop 2

7.14 Glossary of Acronyms

7.15 References

---

---

# 1. Executive Summary

Lake County, along with the nation and other local communities, is facing a behavioral health<sup>1</sup> crisis that affects individuals, families, friends, neighbors, veterans, employers, schools, hospitals, the criminal justice system, the community, and more.

To address this growing problem and strengthen behavioral health services across the county, Lake County established the Lake County Mental Health Coalition (Coalition) in October 2016. The Coalition is made up of a diverse group of stakeholders investing in Lake County behavioral health, representing County government, hospitals, public health, spiritual/religious care, housing/homeless assistance, law enforcement, justice partners, education, advocacy organizations, community health providers, including behavioral healthcare, and private philanthropic funders. The Coalition established a Charter<sup>2</sup>, outlining its aim to prevent and reduce behavioral health illnesses through sharing data and researched-based best practices.

Additionally, case studies have shown that there is a greater chance of success when groups of community-based stakeholders invested in working together on community-level priorities regularly share data and information, coordinate services, and collaboratively organize around outcomes. As a result, the Coalition has initially focused on data sharing and researched-based best practices designed specifically for Lake County to form stronger prevention, build capacity, address gaps, and enhance behavioral health services. To that end, the Coalition commissioned a Data Sharing Project and engaged North Highland to identify data sharing practices and design a future vision for data sharing within Lake County.

The Data Sharing Project included a Current Data Sharing Assessment of Lake County's behavioral health data sharing, a review of existing studies, reports, and programs in the region, as well as identifying available data, missing data, barriers to data sharing, and an analysis of methods to collect transdisciplinary data. Following the Current Data Sharing Assessment, the Data Sharing Project focused on the future vision for data sharing, including identifying the ideal data model, data governance, and action steps to implement.

The Data Sharing Project Report<sup>3</sup> includes this research and the subsequent findings and recommendations, along with "Go First" strategies. The recommendations and Go First strategies are directional in nature and may be implemented as best meets timing and budget considerations. Similar to other comparable community data sharing efforts, the future state vision will take some time to realize, and implementing the Go First strategies will position the Coalition members and stakeholders well to begin sharing data in such a way as to build toward the future state vision.

<sup>1</sup> Although Coalition documents use the term mental, emotional and behavioral (MEB) health, the term behavioral health is used here and throughout this report to be inclusive of mental health (including MEB as used by the Coalition) and substance abuse conditions and/or treatment and to be proactive and consistent with developing national language pertaining to integrated treatment approaches. Behavioral health may be abbreviated within diagrams throughout the document to "BH." Appendix 7.2 Glossary of Terms contains a listing of terms used throughout this document and Appendix 7.14: Glossary of Acronyms contains a list of the terms used within the report.

<sup>2</sup> Additional information about the Coalition's goals, objectives, and guiding principles is located in *Appendix 7.1 Lake County Mental Health Coalition Charter*.

<sup>3</sup> For the remainder of this report, the term Data Sharing Project will be referring to all tasks, activities and outcomes related to the first phase of the Data Sharing Project. The term data sharing initiative will refer to the overall work of the initiative regardless of the phase of the project. This report is authored by North Highland for the Lake County Mental Health Coalition. The report includes an account of the Data Sharing Project activities, and North Highland's analysis and recommendations that outline how the Coalition and behavioral health community members can advance their data sharing initiative and recognize the benefits of data sharing.

## INTRODUCTION

### **Data Sharing Project Purpose and Report:**

The intent of the Data Sharing Project is to support the Lake County behavioral health community's ability to share data for care coordination and the planning and improvement of the behavioral health delivery system. Additionally, the Coalition's goal is to support the Lake County behavioral health system in meeting the behavioral health needs of individuals and families by improving access, responsiveness, and quality of care. The objective is to create an environment in which individuals and families' behavioral health needs are met so they can live the most productive and fulfilling lives they can.

The Data Sharing Project was designed to support the Coalition's goals and objectives and will be implemented in phases. The first phase includes research, a current data sharing assessment, and recommendations that culminate into a future vision, all of which are included in the Data Sharing Report. The second phase entails developing a detailed implementation plan, including a data governance strategy, and implementing data sharing practices.

Data sharing can be difficult, but it is not impossible. To achieve the Coalition's goals and be current with the dynamic local and national landscape, the Lake County behavioral health community needs to begin sharing data. Through research and conversations with comparable communities, it was repeatedly emphasized that these organizations "just got started." They started sharing data incrementally by taking actions like trying out a partnership with another organization, collecting new data, or creating greater awareness of the need to share data.

There have been many incremental activities that support data sharing within Lake County, but never with the direct focus of system-wide data sharing. The ability to get started is influenced by the challenges each organization faces to data sharing as well as technical capabilities and limitations. As each organization has different challenges and capabilities, in order to be able to participate in data sharing, each will need to have individualized paths and starting points. These custom paths do not preclude data sharing activity nor working together towards common goals, rather they enable each organization to contribute at the level they are able to, when they are able to do so.

To "just get started," the Lake County behavioral health community should mobilize on the recommendations in this report, specifically the corresponding Go First strategies, to make progress towards the data sharing vision. The recommendations and Go First Strategies are purposefully directional in nature because how these strategies are operationalized can differ across organizations. As each organization joins in systemic data sharing, the data sharing initiative will grow and evolve. This report should serve as a guide for future actions and to inform future phases of the data sharing initiative, including the implementation plan.

### Data Sharing Project Findings<sup>4</sup>:

The following are the key findings from the research conducted for the Data Sharing Project.

#### Strengths and weaknesses of the Lake County behavioral health community

A review of past and current initiatives surfaced areas of opportunity and positive activities within the Lake County behavioral health community.

- The available reports lack information on or reference to system-wide service performance measurements for the Lake County behavioral health community. Additionally, there is no documentation of the technologies with which data points are collected and shared by service providers. This information is critical for developing a future data sharing model and for system planning and oversight. Members of the Coalition and Lake County behavioral health community will need to establish agreed upon metrics. This report provides a list of metrics as well as information on the data stored across systems and service providers.
- There are many positive activities that are aligned with the goals of the Data Sharing Project and national trends and several of these activities are listed below. The Lake County behavioral health community should leverage the lessons learned and best practices as it moves forward with the Data Sharing Project.
  - Conducting Mental Health First Aid training;
  - Conducting Crisis Intervention Team (CIT) training for emergency response personnel and sworn police officers;
  - Using trauma-informed approaches, such as facility dogs in the Child Advocacy Center;
  - Implementing A Way Out program that is a cross-system collaboration facilitating access to substance abuse treatment;
  - Facilitating a community-wide health and wellness initiative through Live Well Lake County;
  - Mobilizing care coordination best practices through the Mental Health Collaborative;
  - Including organizations and stakeholders that represent the voice of individuals and families with behavioral health needs;
  - Implementing initiatives that work to identify those with the highest needs and are frequent utilizers of cross-system services (e.g. Top 100 jail utilizers initiative);
  - Mobilizing on several justice initiatives (e.g. programs to transition individuals from jail into the community, Data Driven Justice initiatives and SAMSHA's Sequential Intercept Model, updating paper forms and to electronic documentation, including CIT data);
  - Using ServicePoint as a central repository for various initiatives; and
  - Having industry-specific trade organizations provide educational and advocacy support the development of organizations, such as the Alliance for Human Services.

### Technology Infrastructure and Data Sharing

- Currently, there is not a technology solution within Lake County that can immediately be used to collect and report information across systems for the Lake County behavioral health community. A model needs to be designed to meet the needs of the Lake County behavioral health community and the organizations participating in the data sharing model.
- Data sharing is primarily in the form of telephone calls or facsimiles, which are not conducive to electronic data sharing. The electronic systems that store behavioral health information were not designed to serve as a mechanism to interact with behavioral health data as a whole. As a future technology solution is designed, it should utilize and leverage the strengths of the existing systems.
- Some organizations, including behavioral health providers, use nonelectronic or less robust technologies, such as spreadsheets, for internal reporting purposes. Some providers will need to be on a parallel pathway that includes adding capabilities to collect and share data that likely will result in being on a different timeline for participating in data sharing.

### Data Governance

- Within the Lake County behavioral health community, there are a few examples of data collection, analysis, and reporting that utilize some form of data governance. However, there is no current cross-system data governance approach for the Lake County behavioral health community.
- As the community comes together to share data, given the standardization needs and organization-specific compliance requirements, data steward workgroups comprised of representatives from participating organizations are needed and will play a significant role in the development of the future data sharing model.

### Data Sharing Agreements

- Although there are some cross-sector data sharing agreements within Lake County (e.g. use of ServicePoint<sup>5</sup>), there are no current written data sharing agreements that would support a sustainable, on-going cross-sector data sharing program.

### Data Availability

- The types, amount, format, and sharing of the data currently available in the Lake County behavioral health community is not sufficient to provide the desired information consistent with national best practices and prioritized data identified through this project.
- Although there is some data collected that is consistent with best practices for behavioral health communities, there is a need to standardize the collected data as well as significant opportunity to add additional data within all sectors to support the information needs for planning and oversight purposes.<sup>6</sup>
- There is no system-wide aggregated data available for behavioral health system planning and oversight, such as agreed upon metrics for benchmarking, except for the homeless information available through ServicePoint which provides insights into a social determinant of behavioral health.

<sup>5</sup>A copy of the agreement is available in Appendix 7.7 Example Data Sharing Agreements

<sup>6</sup>Appendix 7.10 Data Matrix – Extended List of Data / Measures provides an extended list of data points/measures that are used by behavioral health communities and the matrix identifies if the data is collected and/or standardized within the Lake County behavioral health community.

### Barriers to Overcome

The research surfaced legal, technical, and operational barriers to sharing data. However, there were no barriers identified that cannot be addressed through technology, processes, education, or advocacy. It is important to note that some of the barriers will require significant thought and agreement between system partners to address.

To overcome significant barriers, the future data sharing model will need to:

- Address organizations' reporting, data governance, and resource concerns;
- Alleviate the community's challenges of engaging organizations to participate in light of conflicting priorities;
- Support the Lake County behavioral health community in balancing and emphasizing the value of data sharing with the costs of participating; and
- Enable the flexibility to adapt to new strategies as they arise and address changes outside the control of organizations and the Lake County behavioral health community, such as Medicaid or Managed Care Organizations' (MCO) initiatives.

Several laws are cited as barriers which were designed to protect personal identifiable information (PII) and patient health information (PHI) and which present limitations to sharing participant-level data. Legal or policy restrictions to sharing aggregated data would be unique to each organization based on organization-imposed restrictions. These restrictions and the resulting privacy practices at each organization can be influenced by strict laws, such as the Mental Health and Development Disabilities Confidentiality Act (740 ILCS 110) which focuses on the confidentiality of data rather than promoting data sharing. This barrier may be overcome with a significant and concerted effort to amend the additional restrictions beyond HIPAA and further support data sharing or policies/practices.

### Health and Human Services

The Lake County behavioral health community should become more engaged in and aligned with national and local initiatives that have parallel objectives and that support the Coalition's vision, goals, and guiding principles. Although there are a few examples within the Lake County behavioral health community of embracing and mobilizing on the changes being realized nationally and forthcoming in the state of Illinois, the Lake County behavioral health community as a collective is not aware of or collectively embracing these opportunities. When compared to other communities nationally and locally, the Lake County behavioral health community has an opportunity to enhance its care delivery continuum and clinical and operational practices. Example improvement activities include implementing health homes, using data and technology to identify those with highest needs for care management, and engaging value-based payment models.

### Information Needed and Desired for a Future Data Sharing Model

- There was a general agreement among stakeholders that the information collected and reported on through a data sharing model should reflect the complexity of the entire cross-system behavioral health collaboration effort. This included data from each of the three sectors: healthcare, justice, and community organizations.
- There were three key themes<sup>7</sup> about needed and desired information that repeatedly surfaced during interviews and discussions. The themes were related to being able to answer the following three questions:
  - Who is in need of or seeking behavioral health care and what services do they need?
  - Are the service needs of those accessing behavioral care being met?
  - Are the services provided impacting outcomes and making a difference for the individuals and families served?
- There was general agreement that any approach for the data sharing project should prioritize data needed to answer the three theme questions. The first two theme questions were seen as the most logical place to start seeking answers and to keep the third question in mind throughout the development of the model to then address it in later stages.
- There are several aspects of data sharing that support answering the three theme questions that also need to be included in a future data sharing model.
  - Aggregate level information can help answer some of the questions posed, but participant level information can provide for more robust analysis.
  - For the first and third theme questions, identifiable participant level information needs to be shared to measure the true need and trends overtime. To link participant information from different systems requires a process by which like participants are matched and deidentified as appropriate.
  - To answer the second question, aggregate level information can be used to assess total service demand on the system. However, access to back-end data, such as time stamps for specific information can help assess the timeliness of services.
  - Reporting capabilities must be in place within the model to extract and display the data.
- Stakeholders agreed that any activity relating to obtaining information would need to include:
  - Sequencing of what information is shared
  - Sequencing of what entities would provide what information
  - Phasing of what technology is used to collect data that would be converted to usable information
- There were virtually no standardized system-level performance metrics published or agreed upon to evaluate the performance of the Lake County behavioral health delivery system (e.g. timeliness of services) and these would need to be established to evaluate system-wide trends over time.

<sup>7</sup> Additional information about the themes and questions is available in *Appendix 7.12 Systemic Questions to Prioritize – Workshop 1* and *Appendix 7.13 System Questions to Prioritize Systemic Questions to Prioritize – Workshop 2*.

## DATA SHARING PROJECT VISION AND RECOMMENDATIONS

As a result of connecting all elements of the Data Sharing Project,<sup>8</sup> a Data Sharing Vision was developed with eight recommendations<sup>9</sup> and corresponding sub-recommendations to recognize a future data sharing model for the Lake County behavioral health community.

These recommendations address the short-term and long-term needs of the Coalition in obtaining the necessary information for planning and oversight of the behavioral system, as well as eventually assisting in care coordination and improving care.

The recommendations are directional in nature as they need to be flexible to adapt to changing needs and resources while serving as a guide to move the Lake County behavioral health community forward towards a patient-centered vision. A compass is included throughout the report to emphasize the directional nature of these recommendations.

Arriving at the Data Sharing Vision will take time and be the product of incremental changes. Included in the report are suggested activities, or “Go First Strategies,” for the Coalition to mobilize on to “just get started” on each of the eight recommendations.

<sup>8</sup> For the approach, research, and findings that led to the development of the Recommendations, see sections 2. *Approach*, 3. *Research*, and 4. *Data Sharing Project Findings* within the report respectively.

<sup>9</sup> Additional information on each recommendation can be found in *Section 5. Data Sharing Project Recommendations*.

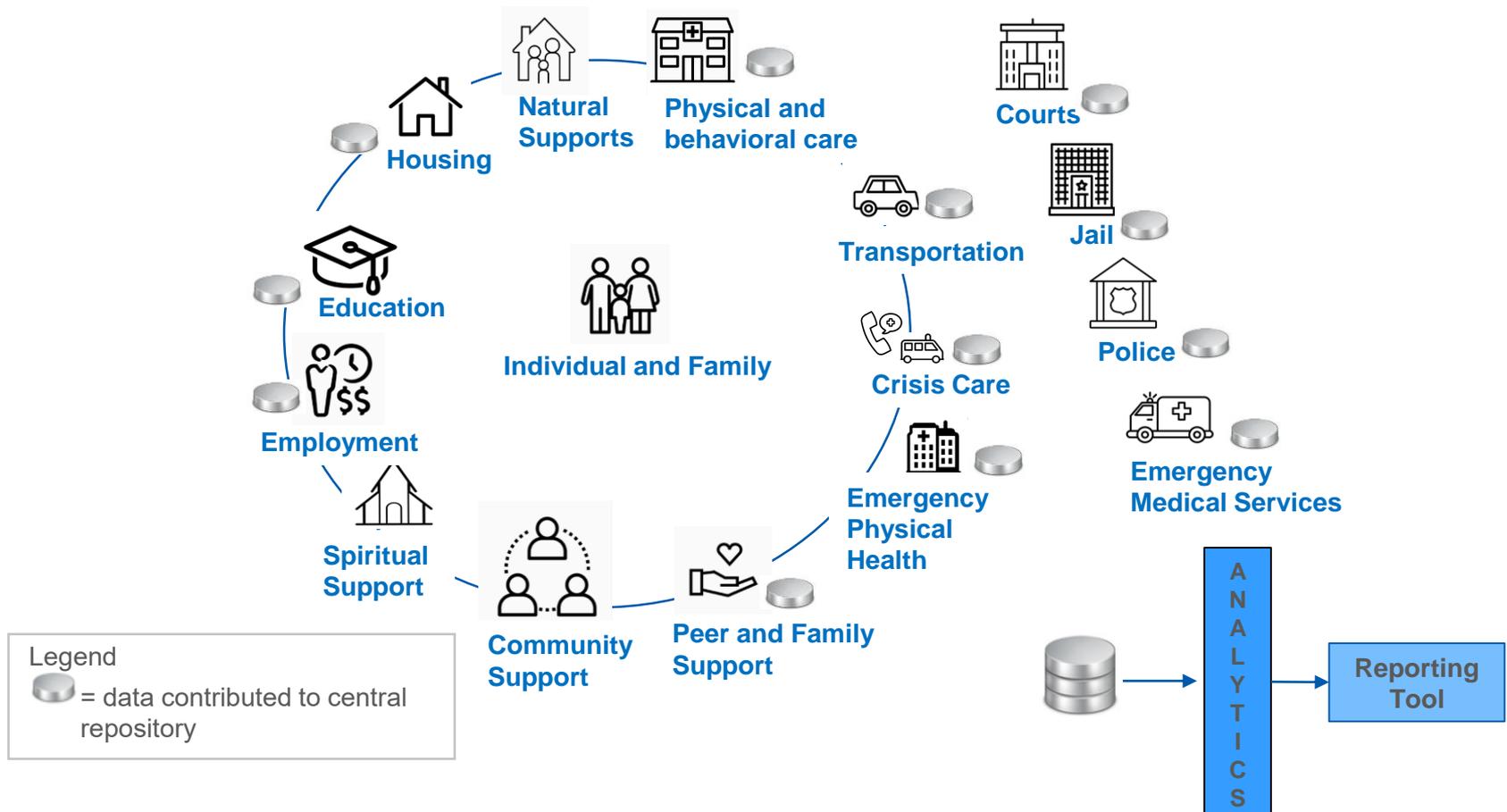
# EXECUTIVE SUMMARY

## DATA SHARING VISION

### Data Sharing Vision

The following Data Sharing Vision diagram represents a person-centered approach to cross-system collaborative data sharing using a central repository. System partners submit individual aggregated data and/or participant-level to the central repository data warehouse which has look-up capabilities for allowable entities/roles to support care coordination. This Data Sharing Vision also supports analysis of data and reporting of information from cross-system partners. The Data Sharing Vision is intended to be implemented in a manner that is consistent with the Coalition's Guiding Principles.<sup>10</sup>

### Lake County Mental Health Coalition Proposed Data Sharing Vision



<sup>10</sup>The Coalition's Guiding principles are located in *Appendix 7.1 Lake County Mental Health Coalition Charter*.

### Recommendations

The following eight recommendations<sup>11</sup> should be pursued to develop a data sharing model and the supporting activities for that model. These supporting activities can be symbiotic with the model, such as data governance, or support the ongoing growth of the data model and best practices within behavioral health, such as MCO partnerships for access to claims data and increased service delivery innovation. Following each recommendation are suggested Go First Strategies<sup>12</sup> or initial actions that will support movement towards the Data Sharing Vision. The Go First Strategies are also directional in nature and can be acted upon concurrently.

**Recommendation 1:** Implement a staged approach to data sharing that results in a centralized ***data warehouse with participant-level data***. This will enable the collection, analysis, and reporting of both aggregated and participant-level data metrics and support care coordination through look-up capabilities.

- A. Design a Data Sharing Pilot Project engaging early adopters from several cross-system partners such as behavioral health providers, Emergency Departments, Lake County Jail and Lake County Probation.
- B. Plan and design a simple and low tech solution for collecting aggregated data and preparing reports.

**Recommendation 2:** ***Implement Data Governance Structures, Standard Operating Procedures, Security, and Processes*** to support sustainable success of data sharing.

- A. Design and implement Data Governance Structures and Activities, including Data Steward Workgroups. Structures should consider some of the short and long-term needs of data sharing initiative such as compliance and data point standardization.
- B. Develop and execute MOUs for all Lake County behavioral health community stakeholders who are willing to commit their efforts toward a data sharing initiative.

**Recommendation 3:** ***Formalize Change Management Structures*** to support continued engagement with the Lake County behavioral health community through all stages of the future data sharing model development and supporting activities

- A. Develop mechanisms to engage all data sharing initiative stakeholders throughout the data sharing initiative stages, regardless of when and how they participate.
- B. Develop and formalize processes to identify, understand, document, and respond to sponsor and stakeholder needs.

<sup>11</sup>Additional suggestions that provide further direction related to each of these recommendations is provided in *Section 5. Recommendations*.

<sup>12</sup>Additional information is located in *Section 6, Coalition Preferred Action Plan and Go First Strategies*.

### Recommendations Cont.

**Recommendation 4:** *Foster relationships with the Illinois Medicaid Agency and Medicaid Managed Care Organizations (MCOs)* to align with common goals and strategies for data sharing and delivering exceptional behavioral healthcare.

- A. Understand the MCO plans outlined in their Medicaid proposals that are in alignment with and can support data sharing in Lake County.
- B. Understand and foster partnerships with MCOs on Illinois Medicaid initiatives.

**Recommendation 5:** *Accelerate the adoption of modernized healthcare, business operations, clinical best practices* that achieve better outcomes, experience, and efficiencies.

- A. Identify and communicate to behavioral health providers national and other local learning opportunities that are focused on health care transformation initiatives that support the acceleration of clinical best practices and business operations such as data sharing and interoperability.
- B. Develop learning opportunities that are targeted to the specific needs of behavioral health providers within Lake County.

**Recommendation 6:** *Support expansion or shifts in the behavioral health services continuum* to better align services with community needs.

- A. Develop strategies for expanded support services and crisis services that include an emphasis on the most contemporary clinical and operational best practices that support individuals and families in community settings such as crisis mobile teams operating and crisis follow-up services.

**Recommendation 7:** *Influence federal and state laws* that support the active sharing of information to coordinate care, while also safeguarding privacy.

- A. Develop strategies to either amend or repeal the Mental Health and Developmental Disabilities Act (740 ILCS 110) to support the active sharing of information to coordinate care while also safeguarding privacy in alignment with federal laws including the Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH) laws.
- B. Identify strategies to engage lawmakers about current initiatives to amend laws (Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2)) to support the active sharing of information to coordinate care while also safeguarding privacy (i.e., sending letters to senators/representatives, and thereby taking an active role in the federal dialogue).

**Recommendation 8:** *Explore potential funding mechanisms* to establish a financially sustainable data sharing program.

- A. Research federal funding and local and private funding opportunities.

### Conclusion

Through the Data Sharing Project, members of the Coalition and Lake County behavioral health community can work together on priorities and drive community-level change with evidence-based decision making.

Data sharing can be difficult, but by recognizing what can be shared, phasing the activities needed to establish an on-going, sustainable data sharing model, and taking actions towards a data sharing vision, organizations can recognize small wins along the way that benefit the behavioral health community and individuals with behavioral health needs. The end result will be information at a system level that can inform future improvements for the Lake County behavioral health community.

The challenges to data sharing as surfaced through the Data Sharing Project's research include legal, operational, and technical difficulties at both the organization and system level. Additionally, changes outside of the Lake County community such as MCO engagements, state policies, and national trends provide opportunities for the behavioral health community to advocate for and support increased data sharing. This can manifest itself through partnerships with MCOs, amendments to state policies that restrict data sharing, and/or on-going education on operationalizing national and local trends to accelerate the adoption of new practices.

The recommendations to assist in addressing these challenges should be done concurrently as they are symbiotic, as is the case with the data sharing model and data governance, and mutually beneficial. The Recommendations and corresponding Go First strategies will provide for the best chance of success for a system-wide data sharing model that can answer the questions prioritized by the Lake County behavioral health community. By adopting all eight recommendations, organizations can determine which recommendations to operationalize first and then partner with other organizations to address the chosen strategy, take action to drive a data sharing model forward, and begin making evidence-based decisions to improve the Lake County behavioral health community.

The Lake County behavioral health community can now “just get started” on data sharing with a purposeful direction. The Lake County behavioral health community can begin focusing on Phase 2 of the Data Sharing Project and operationalizing how the directional recommendations and corresponding Go First strategies can be implemented to move organizations and the community toward the future data sharing vision. Following the development of such an implementation plan, the Lake County behavioral health community will have the information, sequencing, and detailed action steps needed to begin implementing its data sharing model and will develop system-level metrics to use for the planning and oversight of the Lake County behavioral health community.

---

## **2. Data Sharing Project Overview and Approach**

## *2.1 Lake County Mental Health Coalition Overview*

## 2.1 LAKE COUNTY MENTAL HEALTH COALITION OVERVIEW

Lake County, along with the nation and other local communities, has been facing a behavioral health crisis that affects individuals, families, friends, neighbors, veterans, employers, schools, hospitals, the criminal justice system, and more.

To address this growing problem and strengthen behavioral health services across the county, since August 2016, Lake County Board Chairman Aaron Lawlor and the Honorable Susan Garrett (former IL State Senator, 29th District) have lead a community-wide initiative focusing on data-sharing and evidence-based practices to identify gaps and recommend a sustainable continuum of care for Lake County.

The community-wide initiative of focusing on data-sharing and evidence-based practices is being coordinated by the recently established Lake County Mental Health Coalition (Coalition).

The Coalition consists of representatives from a diverse group of impacted organizations:

- Government
- Hospitals
- Public health
- Spiritual/clergy/religious/pastoral care
- Housing/homeless assistance
- Law enforcement
- Justice partners
- Education
- Advocacy organizations
- Community health providers, including behavioral healthcare, and
- Private philanthropies

# LAKE COUNTY MENTAL HEALTH COALITION MEMBERS

Following is a list of individual Coalition Members:

- Aaron Lawlor (Co-Chair)  
Lake County Board Chairman
- Susan Garrett (Co-Chair)  
Former Illinois State Senator, 29th District
- Christen Bishop  
Associate Judge, 19<sup>th</sup> Judicial Circuit Court
- Mark C. Curran  
County Sheriff, Lake County
- Jesse Peterson Hall  
President, Highland Park Hospital at NorthShore University Health System
- Rich Haney  
Provost, College of Lake County
- Jennifer Harris  
President, CR Search, Inc
- Sandra Hart  
Board Member District 13, Lake County
- Mark Ishaug  
CEO, Thresholds
- Mary Jouppi  
President, NAMI Lake County
- Dora Maya  
Mental Health Collaborative
- Michael Nerheim  
Attorney, Lake County State's Attorney's Office
- Kathy Pierson  
Lake County United
- Timothy Sashko  
President, Board of Health
- Dr. Debra Susie-Lattner  
VP Medical Management, Advocate Condell Medical Center
- Mary Ellen Tamasy  
President, LCRDC - Lake County Residential Development Corporation
- Ernest Vasseur  
Executive Director, Healthcare Foundation of Northern Lake County
- Barbra Martin  
President and Chief Executive Officer Vista Health Systems

## LAKE COUNTY MENTAL HEALTH COALITION CHARTER

To focus its vision and activities, the Coalition developed and approved a Coalition Charter. The Charter outlines the Vision, Mission, stakeholders, and desired outcomes of the Coalition. The Charter also documents the guiding principles, outcomes, responsibilities and general principles of collaboration.

The Coalition has adopted their vision from the Illinois Mental Health Services Strategic Planning Task Force, Illinois Mental Health Strategic Plan vision. The Coalition's vision is:

*In Illinois, we envision: All adults with a diagnosis of, or at risk for developing, a mental illness will have access to a coordinated, integrated, well-funded mental health system that promotes recovery and social inclusion through timely access to prevention, treatment, and recovery support services.*

The Coalition Charter's purpose is:

*The purpose of the Lake County Mental Health Coalition is to advance sustainable community level change through collaborative efforts, such as enhanced system-wide data sharing, coordination, and collaboration, in order to better leverage existing limited resources and maximize the impact. Additionally, the LCMHC will work collaboratively to develop a positive public awareness campaign to decrease stigma and increase an awareness of available resources for mental, emotional and behavioral (MEB) health needs.*

The full text of the Coalition Charter can be found in the *Appendix 7.1 Lake County Mental Health Coalition Charter*.

## *2.2 Data Sharing Project Purpose*

## 2.2 DATA SHARING PROJECT PURPOSE

The Coalition intends to promote improved care coordination and evidence-based decision making across-sectors to better address the needs of individuals with behavioral health needs. Towards that end, the Coalition has embarked on a Data Sharing Project.

The intention of the Data Sharing Project is to support the Lake County behavioral health community's ability to share data for care coordination and the planning and oversight of the behavioral health delivery system. Greater access to data can support all the system partners that are engaged in working with individuals and families with behavioral health needs by improving access, responsiveness, and quality of care and enabling the right care at the right time. The ultimate goal is to create an environment in which individuals and family behavioral health needs are met so they can live the most productive and fulfilling life.

“The Data Sharing Project was designed to support the Coalition's goals and objectives and will be implemented in phases. The first phase includes research, a current data sharing assessment, and recommendations that culminate into a future vision, all of which are included in the Data Sharing Report. The second phase entails developing a detailed implementation plan, including a data governance strategy, and implementing data sharing practices. This report conveys the process used, findings, and outcomes for the first phase. “

Experience and research of other communities that attempted to address similar behavioral health concerns suggests that these communities “just got started” sharing data. They started sharing data incrementally by taking actions like trying out a partnership with another organization, collecting new data, or creating greater awareness of the need to share data. The result of this first phase will provide a direction with which the Lake County behavioral health community can take action to recognize a future data sharing vision that provides the community with the tools and information needed for improved oversight.

The Coalition Charter conveys that the purpose of the Coalition is to advance sustainable community-level change through collaborative efforts, in order to better leverage existing limited resources and maximize impact. Methodologies to be considered include, but are not limited to, enhanced system-wide data sharing, coordination, and collaboration.

**The development of a systematic, coordinated network that promotes care, recovery, and social inclusion through timely access to prevention, treatment, and recovery support can yield the following benefits:**

## DATA SHARING GOALS:



### IMPROVED ACCESSIBILITY & SERVICES

Communities with provider shortages gain access to in-demand specialists



### JAIL DIVERSION

A coordinated system can align individuals with their needs earlier and avoid legal and criminal events



### DECREASED COST

Early intervention and less acute cases from consistent coordinated care



### CARE COORDINATION

Systematic tracking and case management of patients can support improved behavioral health outcomes



### IMPROVED PATIENT EXPERIENCE

Improve patient satisfaction by reducing wait times and reduce attrition in the system



### HIGHER QUALITY DATA

Coordinated systems surface data to make decisions on behalf of individuals with behavioral health needs



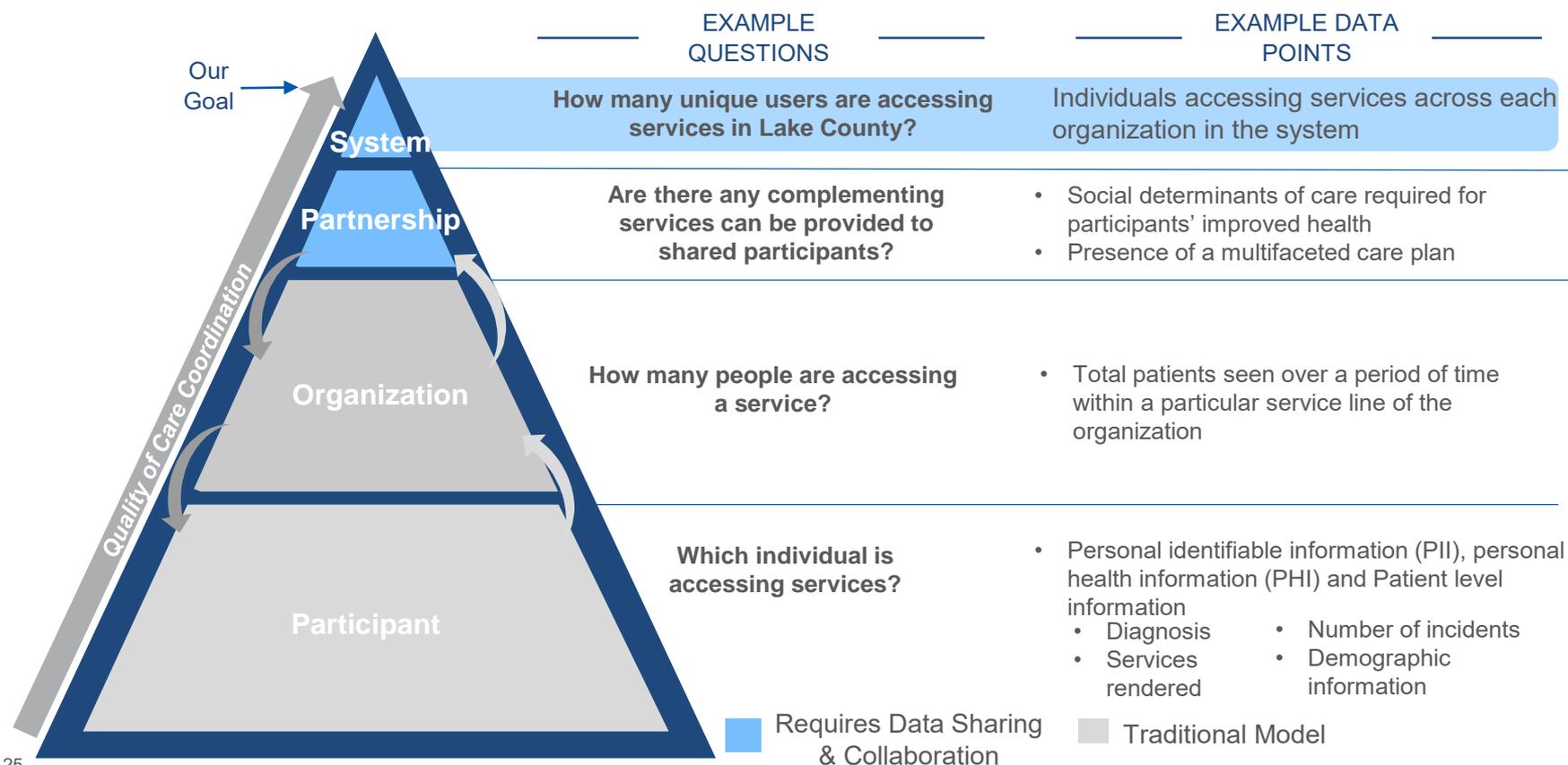
### CLINICIAN SATISFACTION

Automation reduces time spent on tasks (i.e. phone calls versus timely electronic messaging)

# DATA SHARING PROJECT FOCUS

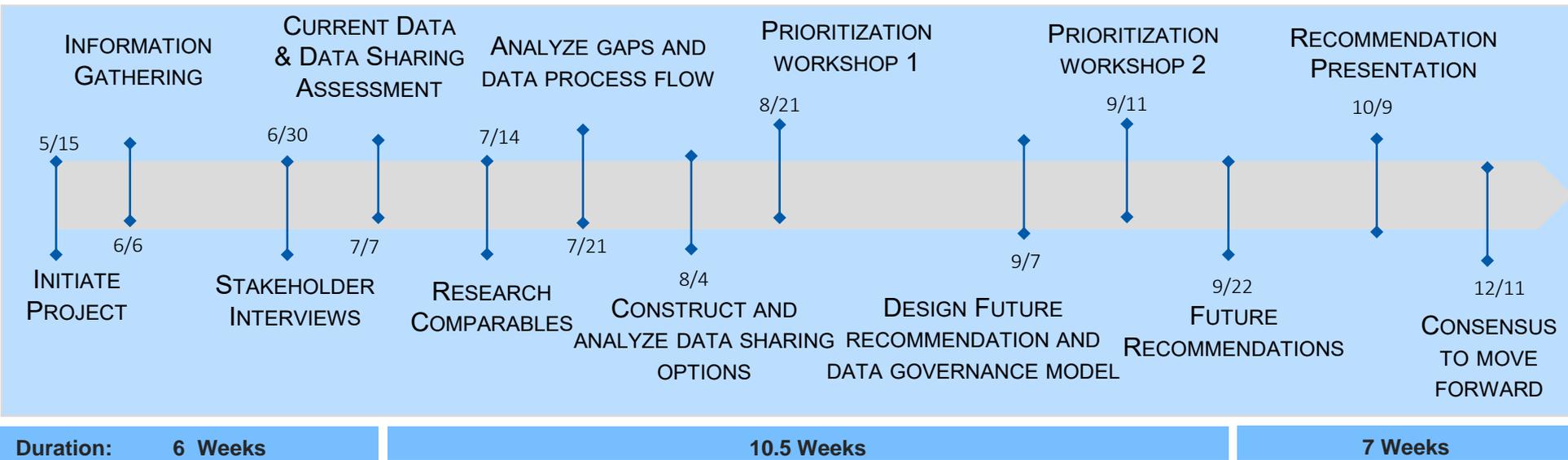
Many communities use data to support their future planning, for measuring needs and identifying if goals are being realized. Within the healthcare and behavioral healthcare field, this is also the case. Many government entities, insurance / managed care companies, accountable care organizations and other similar entities use data for such tasks as planning, population health management, and outcomes measurement. These entities will look to **aggregated data** to accomplish the tasks previously listed.

One of the key priorities of the Data Sharing Project is to support the Coalition in developing a vision for the future in which data is available at the system level for planning and oversight purposes. As such, throughout the project, there will be a focus to assess current abilities of sharing aggregated data – while also identifying additional methods of data sharing. The diagram below reflects how data can be collected at the participant-level and disseminated to authorized entities. The diagram conveys the types of questions that can be answered at each level. This concept has been discussed at several Coalition meetings.



# PROJECT TIMELINE

## HIGH LEVEL REVIEW OF PROJECT TIMELINE



The above is a high level timeline of the project approach beginning in late May and extending through mid November. The activities featured above include key processes and milestones.

## *2.3 Data Sharing Project Approach*

## 2.3 DATA SHARING PROJECT APPROACH

The Data Sharing Project approach included the following activities:

- Visioning Session
  - with members of the Lake County Government and Mental Health Coalition Co-Chair Susan Garrett to begin the project with agreement on direction and understanding of the project needs.
- Research
  - national and local landscape
  - current practices regarding data sharing within behavioral health communities.
  - comparable communities in which data sharing occurs within a behavioral health system.
- Assessment of the current data sharing practices within Lake County behavioral health community
- Facilitated Discussions
  - to assist the Coalition in coming to a consensus on a future vision for data sharing and develop high-level strategies for data sharing within the Lake County behavioral health community.



Additional detail on each of these activities is described in the following pages.

## 2.3.1 VISIONING SESSION

At the onset of the project, a visioning session was conducted with leaders within the Lake County Government and the Coalition Co-Chairs to gain an in-depth understanding of the purpose and objectives of the Coalition's data sharing initiative. The discussion included a review of the Coalition's history and reasoning for establishing the Coalition, the key information needed to inform planning and oversight tasks, and the types of data that might be helpful to obtain key information about the system of care. The discussion surfaced the needs of the Lake County behavioral health community that could be addressed through data sharing.

	IMPROVE DATA SHARING	IDENTIFY DATA ACROSS THE COUNTY
PROJECT GOALS	<ul style="list-style-type: none"> <li>• Understand data sharing across the Lake County behavioral health community</li> <li>• Surface existing data sharing partnerships across the Lake County behavioral health community</li> <li>• Understand the enablers and barriers to sharing data &amp; identify motivators for sharing data</li> <li>• Recommend future sharing partnerships based on early adoption characteristics</li> </ul>	<ul style="list-style-type: none"> <li>• Identify existing data points and measurements</li> <li>• Determine key decisions that need to be made at the community level using data</li> <li>• Identify gaps in the data available to make those decisions</li> <li>• Recommend data points needed</li> <li>• Stratify which data points will be easier to produce and surface</li> </ul>
SYSTEM NEEDS	<ul style="list-style-type: none"> <li>• Care Coordination – improved warm hand-offs, feedback loops, and participant monitoring</li> <li>• Data, analytics and transparency – currently relying on anecdotal data</li> <li>• Improved access to care – Cultural and stigmatizing beliefs impact desire to access care</li> <li>• Increased availability: behavioral health system capacity – lack of psychiatrist, lack of consensus of types and amounts of services (e.g. crisis)</li> </ul>	<ul style="list-style-type: none"> <li>• What is needed to adequately address the psychiatric medication assessment and monitoring needs in Lake County?</li> <li>• What services are needed (e.g. crisis center, community mobile response teams) to support timely access to community-based services diverting from individuals from hospital emergency rooms and jails?</li> <li>• Are resources being managed accurately and used efficiently (e.g. duplicate or delayed services)?</li> </ul>

## 2.3.2 RESEARCH APPROACH

### Research Approach Introduction

This section provides information about the project's research approach. Greater detail surrounding the research can be found in section 3.1 *Research Review* while the key findings from the research are located in section 4. *Data Sharing Project Findings*.

Throughout the work of the Data Sharing Project, research was conducted on the following behavioral health topics:

- Current Lake County behavioral health community data sharing practices
- Initiatives underway and planned within the Lake County behavioral health community
- National and local initiatives and trends impacting this project
- Cross-system collaboration strategies
- Data sharing technologies, policies, and methodologies
- Behavioral healthcare
- Healthcare

Information was obtained in the following ways:

- Lake County Government provided materials
- Stakeholder provided materials
- Behavioral health community provided reports and evaluations
- Interviews and research were conducted to obtain national and local trends regarding healthcare, behavioral healthcare, cross-system collaboration strategies, data sharing approaches, and technical aspects of data sharing.

### Related Documentation Research

- The Lake County Government provided many documents at the onset of the project for the North Highland team. The documentation consisted of many studies on Lake County initiatives, comparable communities' practices, and cross-sector efforts related to behavioral health.
- North Highland read these to become familiar with the opportunities, strengths, and weakness of the existing information within Lake County. This information helped to inform the organizations in Lake County that serve behavioral health individuals, concurrent local and national trends that can impact behavioral health, as well as the impact on data sharing.

## RESEARCH APPROACH – CONTINUED

### Research of and Interviews with Comparable Communities' Data Sharing

Research was conducted to identify communities throughout the nation with data sharing experiences that could help inform data sharing within the Lake County behavioral health community.

Of the many communities reviewed, several communities were selected for additional research based on their comparability to the needs of the Lake County Data Sharing Project.

The map on the following page shows the all the communities that were initially looked at and the communities that were finally selected to conduct additional research.

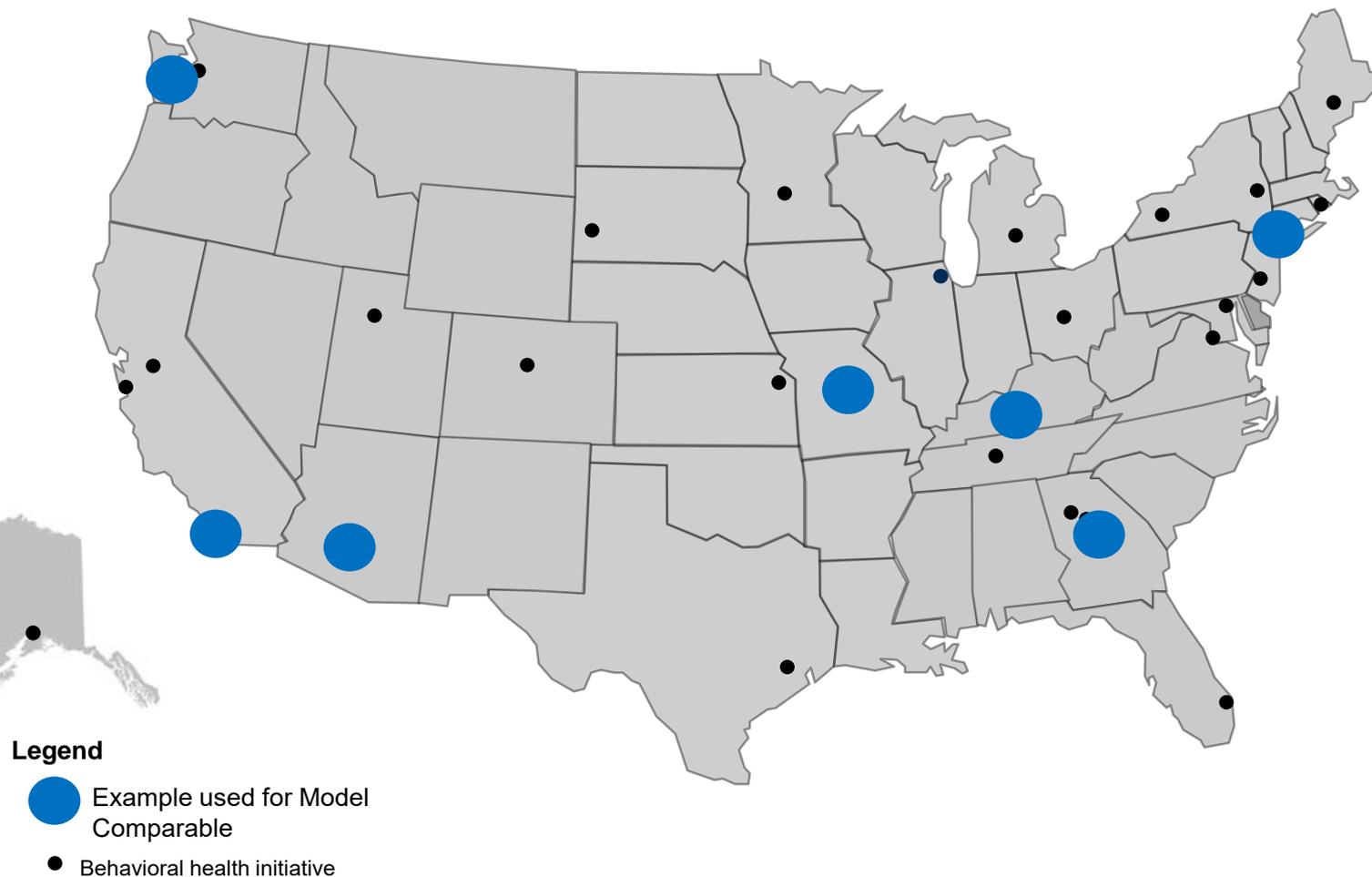
The comparable communities researched were:

- Live Well San Diego, San Diego, California
- Familiar Faces, King County, Washington
- Community Care Management Network, Louisville, Kentucky
- Multiple Programs, Johnson County, Kansas
- NurseWise, Southern Arizona
- Behavioral Health Link, Georgia
- Camden Health Information Exchange (HIE) and Camden Arise, Camden, New Jersey

Some of the communities were very willing and helpful to engage in an interview process. Others were less engaged resulting in the majority of information having been obtained via the internet or conversations with others familiar with the community.

## COMPARABLE COMMUNITIES RESEARCHED

The following map identifies the communities that were considered for conducting more research and the location of the aforementioned communities that were selected for additional research. Some of the behavioral health initiatives not discussed in the following pages include Miami Dade Stepping Up Initiative, CIT Utah, Anchorage Coalition to end Homelessness, 100,00 Homes Campaign, Centerstone, and several statewide HIEs including Ohio CliniSync, Rhode Island Current Care, and Arizona Health-e Connection. North Highland focused its efforts on cross-sector initiatives that could be applied to Lake County and that were not enabled by state-wide HIEs for further research as Illinois currently does not have an HIE.



## 2.3.3 CURRENT DATA SHARING ASSESSMENT APPROACH

### Assessment Approach

The approach to conducting a Current Data Sharing Assessment included:

- Reviewing background information on the initiatives and organizations associated with the Lake County behavioral health community
- Identifying and coordinating stakeholders to interview
- Preparing and developing an interview questionnaire focused on both functional and technical aspects of collecting and utilizing data
- Conducting interviews
- Summarizing information obtained through the review of background information and interviews

### Interview Approach

The interview approach was designed to capture greater qualitative and contextual information, while simultaneously developing buy-in for the initiative. Interviews offered an opportunity for real-time feedback to questions a stakeholder may have. Coalition Members and stakeholders were asked to recommend additional stakeholders/ organizations to interview. The intention was to sample stakeholders/organizations to afford a broad range of perspectives about data sharing within the Lake County behavioral health community, rather than an exhaustive-interview process involving all the stakeholders within the Lake County behavioral health community. Efforts were made to ensure representation from several types of organizations including community health; community behavioral health; emergent services including crisis services, emergency departments and psychiatric inpatient hospitals; justice partners, and community organizations representing housing, community support, and advocacy. Organizational representatives who participated included a range of staff including senior executives, senior management, front-line operational staff, and data and technical analysts. A list of the interviewees is available in the Appendix, *Appendix 7.3 Current Data Sharing Assessment Interviewee List*.

The information collected from the interviews is available in section *3.2 Current Data Sharing Assessment*.

# CURRENT DATA SHARING ASSESSMENT APPROACH

## INTERVIEW APPROACH

### Interview Questionnaire

An interview questionnaire was developed that focused on obtaining information pertinent to understanding the current status of data sharing across the Lake County behavioral health community. The Interview Guide is located in the Appendix, *Appendix 4. Current Data Sharing Assessment Interview Guide*. As interviews were scheduled and conducted, the exact questions utilized were customized to address the organization's role in the Lake County behavioral health community. For example, an advocacy organization is not delivering services, and therefore does not collect service data, would not have been asked about the data they collect but would have been asked about preferences for future data metrics. The intent of the interviews was to gather information on topics such as but not limited to:

- Current clinical and operational practices
- Current data sharing practices including method and types of data shared
- Current use of data to inform practices within or across organizations (e.g. data measures/ metrics)
- Current systems, applications, and methods used for data sharing
- Barriers to data sharing
- Preferences for future data sharing approaches and data metrics
- Initial input on a future public awareness campaign.

The interviews largely focused on the Data Sharing Project but presented an opportunity to begin socializing another Coalition charge of a public awareness campaign. The highlights from these discussions is located in the Appendix, *Appendix 7.6 Public Awareness Campaign Socialization*.

Two types of interviews were planned, Functional and Technical. Functional interviews were aimed at discovering data collection, standardization, and sharing practices and were typically conducted with senior executive and director of development roles. Technical interviews, on the other hand, were aimed at discovering the mediums through which information was shared, the programs and systems used, and, if information was shared, how it was technically shared. Several technical questions could be answered by business contacts and some contacts deferred to systems specialists who were also interviewed, such as data analysts.

### Interview Schedule

Originally scheduled for a maximum of three weeks, Functional and Technical interviews received so much interest that the interview period was extended to five weeks. Additional clarification or questions after the interviews were conducted via e-mail and/or telephone.

## 2.3.4 FACILITATED DISCUSSIONS APPROACH

### Facilitated Discussions

As with all community-based system change, the Coalition's intention to create community-wide system change for the Lake County behavioral health community must be responsive to the needs of individuals, families and system partners. This requires the deployment of intentional approaches in order to effect the desired change and gain the unified support of Coalition members and behavioral health community members.

As such, the Data Sharing project employed enabling methodologies to facilitate the Coalition and behavioral health community members movement towards an agreement on a data sharing vision and the development of high-level strategies for data sharing.

To ensure that the Coalition develops a unified vision and goals, the Coalition held facilitated discussions to:

- Provide learning opportunities for the Coalition Members and stakeholders by presenting research and information at the Coalition meetings and designed workshops
- Afford the Coalition Members and stakeholders opportunity to review research and information outside of formal gathering and develop their preferences designed around targeted questions and to bring back their ideas to future gatherings for further discussion
- Facilitate discussions with the Coalition Members and stakeholders that informs the development of a data sharing vision and of high-level strategies for data sharing
- Synthesize information that surfaced through facilitated discussions and present ideas for future discussion and general agreement
- Come to general agreement on a data sharing vision and the development of high-level strategies for data sharing.

## FACILITATED DISCUSSIONS

### COALITION MEETINGS

The Coalition met in October 2016 and monthly between the months of January - November of 2017. The following is a summary of the topics discussed at each meeting.

October 2016 – April 2017: Coalition members heard from members of the Lake County behavioral health community through presentations as to how behavioral health impacts service providers for the physical, mental, and societal determinants of health and the community. Coalition members also learned of concurrent initiatives within the community related to behavioral health, such as the Lake County Health Departments telepsychiatry program.

May 22, 2017 – The May meeting kicked off the Data Sharing Project with an introduction to the project, its purpose, the benefits of data sharing, and an overview of the timeline. Information was presented on the approach to the project inclusive of conducting a literature review and research as well as conducting a Current Data Sharing Assessment that would have interviews as part of the design. Coalition and community members were asked for contacts of potential interviewees. At the end of the meeting, Coalition Members and stakeholders discussed how this initiative differs from some of the other concurrent initiatives related to behavioral health.

June 12, 2017 – Coalition Members and stakeholders discussed the importance of data sharing and the value it can generate specifically for Lake County. Poll Anywhere technology was used to capture Coalition Member and stakeholder's input on: 1) the needs of the Lake County behavioral health community, 2) comparable communities that have done similar work, and 3) what benefits Lake County specifically can recognize through data sharing. The Poll Anywhere results are provided in the Appendix, *Appendix 9. Poll Everywhere June Meeting Results*.

July 17, 2017 – Coalition Members were presented with the research, key findings, and analysis from the Current Data Sharing Assessment. This information presented included: a review of the approach, key insights, sector analysis (Strengths, What's in it for me, Opportunities and Barriers), assessment of data available and its current use for reporting, overall barriers and next steps. This information is included in the *3.2 Current Data Sharing Assessment*.

August 21 and September 11, 2017 – Coalition Members and stakeholders participated in two workshops. The workshop content included information about comparable models in other communities, key questions/information needed to address system needs, data to use to address system questions and theoretical models for Lake County behavioral health community. The information from these discussions was used to develop recommendations.

October 9, 2017 – Coalition members reviewed the key recommendations and corresponding Go First Strategies to progress towards a future data sharing vision designed for the Lake County behavioral health community given the research, key findings, and Coalition's input throughout the Data Sharing Project. The Recommendations and Go First strategies are available *in Section 5. Recommendations and Section 6. Coalition Preferred Action Plan and Go First Strategies*.

## FACILITATED DISCUSSIONS WORKSHOPS

The August 21<sup>st</sup> and September 11<sup>th</sup> differed from the monthly meetings in that they were interactive workshops. The two workshops were designed and conducted to provide Coalition Members and stakeholders information on the research conducted and then to facilitate discussions regarding such content. The purpose of the facilitation was to engage the group through a process to align and eventually come to a general agreement on a data sharing vision and Go First Strategies that will begin to mobilize the behavioral health community toward the agreed-upon vision.

The first workshop predominantly focused on educating Coalition Members and stakeholders about the research conducted. At the conclusion of the first workshop, Coalition Members and stakeholders had time to reflect on the materials and discussed their findings with their organizations and came prepared to the second workshop to share their preferences on specific topics. The second workshop included a brief review of the information presented at the first workshop followed by a series of facilitated discussions on each topic covered.

The content of these discussions are available in the research section under *3.3. Facilitated Discussions*.

---

## 3. Research

# RESEARCH

This section contains the materials generated for the research conducted during the Data Sharing Project Report. The topics covered in this section include:

- Reviews of the research materials:
  - Prior Reports/Evaluations of Lake County Initiatives
  - National and Local Trends Impacting Behavioral Health
  - Comparable Data Sharing Models from Other Communities
  - Theoretical Models
  - Data Governance Approaches
  - Data Sharing Agreements Laws Impacting Sharing Of Data In Lake County Data Privacy Practices
- The Current Data Sharing Assessment, including:
  - Introduction to the Current Data Sharing Assessment
  - Sector Analysis from Interviews
    - Healthcare Organizations
    - Justice System
    - Community organizations
  - Current Data Sharing Technology
  - Current Data Sharing Availability and Existing Partnerships
  - Barriers to Data Sharing
  - Legal Considerations to Data Sharing Change Management Status
- The information surfaced during facilitated discussions

## *3.1 Research Review*

## 3.1.1 PRIOR REPORTS/EVALUATIONS OF LAKE COUNTY INITIATIVES DOCUMENTATION REVIEW

Research was conducted to identify the strengths and opportunities of current and past activities, studies, and evaluations of Lake County including a comparison to other national and local initiatives.

Reports, materials and other information that were reviewed were either provided by Lake County Government or stakeholders; or obtained through an internet search.

A complete list of all documents studied can be reviewed in Appendix 7.14 *References*. The following are topics and documents that were researched and reviewed related to the **Lake County behavioral health community**:

- Behavioral health needs assessment, capacity, and trends;
- Behavioral health strategic plan;
- Community health assessments;
- Community health and wellness improvement plans;
- Specialty project research and plans such as:
  - An assessment on improving jail diversion; and
  - 911 Consolidation Project;
- Presentations provided to the Coalition intended to educate or update the members:
  - About services offered and initiatives underway
  - Community and advocacy organizations
  - On status of initiatives or progress on strategic plans
- Summary presentations of data sharing projects in Illinois and Lake County
- Summary presentations of laws impacting data sharing in Illinois and Lake County

# DOCUMENTATION RESEARCH

## DOCUMENTS REVIEWED

The following are topics and documents that were researched and reviewed related to **national and local initiatives and trends**:

- Summary reports of initiatives in other communities
  - Presentation of an overview of the Camden Coalition of Healthcare Partners demonstrating their work regarding data sharing and analytics
  - Presentation of ways to use data sharing and analytics and how it can improve care for individuals who have complicated needs and are accessing care across system partners
  
- Publications regarding:
  - Cross-system collaboration strategies;
  - Changing national healthcare delivery system strategies to address unsustainable rising costs, improving quality of care and improving the experience of care;
  - Changes in the types of and methods of delivering behavioral health services such as a focus on community-based care over facility-based care, use of peer and family support services, transportation, and housing support.
  
- Websites of Illinois or Lake County organizations that are associated with interacting with individuals and families who have behavioral health needs such as:
  - Illinois State Government departments:
    - Illinois Department of Healthcare and Family Services (Medicaid agency); and
    - Illinois Department of Human Services (State Mental Health Authority).
  - Lake County Departments:
    - Jail;
    - Court;
    - Health
    - Human services; and
    - Housing.
  - Providers of behavioral health services.

## DOCUMENTATION RESEARCH

### OBSERVATIONS FROM SPECIFIC DOCUMENTS

The following is a brief description of some of the specific materials reviewed that relate to data sharing, healthcare, or behavioral health within Lake County and North Highland's observations as it relates to this Data Sharing Initiative. There have been incremental activities that support data sharing within the Lake County behavioral health community, but never with the direct focus of system-wide data sharing.

The **Lake County Mental Health Coalition** document provided an overview of the Lake County Mental Health Coalition, the participants, what services exist in Lake County, objectives, and desired outcomes. It also listed, by category (e.g., housing and homelessness, homelessness – veterans, medical/hospitals, etc.), the facts known to the Coalition and questions for which the answers are not known.

**Opportunity Related to Data Sharing Project:** As the Current Data Sharing Assessment is conducted and future data sharing facilitated discussions occur throughout the project, the “What We Don’t Know” questions from the Lake County Mental Health can be incorporated to understand what types of information is needed by Lake County to support identifying what information is needed by the Lake County behavioral health community for planning and have oversight.

The **Assessment of Behavioral Health Needs, Service Capacity, and Projected Trends in Northern Lake County** (2014) conducted by Rob Paral and Associates described behavioral health in terms of needs, service capacities, and projections for the future in Northern Lake County, especially as related to lower-income populations. The following is a list of the findings related to needs and capacity:

#### *Findings on Needs:*

- The Need is Enormous
- Large Numbers of Young Adults are Using Alcohol and Tobacco
- Young Persons are overrepresented in hospital emergency departments for behavioral health
- The Need is Highly Concentrated in Some Areas
- Specific Populations are Underserved in Different Ways
- Critical Services Are Lacking.

#### *Findings of Capacity*

- There Is Limited Capacity
- More Medicaid Providers Are Needed
- The Lake County Health Department Has Experienced Shifts in Its Service Capacity, with Some Decline of Services in Recent Years

**Opportunity Related to Data Sharing Project:** This study provided significant insight into the behavioral needs of individuals and families and what capacity deficits exist in Northern Lake County at the time the study was conducted or a one time view of what occurred in prior years. There is an opportunity to collect data on an on-going basis to show trends related to needs and capacity and to have data that in, or almost in, real time.

## DOCUMENTATION RESEARCH

### OBSERVATIONS FROM SPECIFIC DOCUMENTS

The *Lake County Health Department and Community Health Center - Community Action Plan for Behavioral Health in Lake County, Illinois (2016-202)* prepared by Leading Healthy Futures provides a recommended five-year action plan to address the unmet behavioral health needs in Lake County that were outlined in the aforementioned report developed by Rob Paral and Associates.

This report presents detailed discussions of 13 unique strategies, grouped according to the underlying four issue areas listed below:

#### *Provider Workforce*

- Strategy 1: Develop programs (i.e. internships, residencies) for behavioral health trainees
- Strategy 2: Develop a program of international recruitment and joint recruitment of behavioral health professionals
- Strategy 3: Expand the use of telepsychiatry in Lake County

#### *Coordination/Continuum of Care*

- Strategy 4: Integrate behavioral health services into primary care settings
- Strategy 5: Integrate primary care services into behavioral health settings
- Strategy 6: Develop a referral network among agencies in Lake County
- Strategy 7: Expand the use of technology to facilitate the continuum of care in Lake County, specifically the number of agencies that use technology to send and receive referrals

#### *Access*

- Strategy 8: Co-locate behavioral health providers and other social service agencies in one location to improve access to services
- Strategy 9: Expand supportive housing services for individuals with severe mental illness (SMI)
- Strategy 10: Develop school-based behavioral health services to increase access to services for youth
- Strategy 11: Develop a program to provide transportation to appointments for individuals with behavioral health needs

#### *Awareness*

- Strategy 12: Train individuals in Mental Health First Aid
- Strategy 13: Design and implement a public awareness campaign

***Opportunity Related to Data Sharing Project:*** Not all of these initiatives will result in significant on going data in it of themselves, for example increasing the number of individuals that are trained in Mental Health First Aid. However, the intended outcomes of these strategies may be measured by agreed-upon data points and once those data points are determined and collected, that outcome data could be incorporated into a future data sharing model should the data be in alignment with the information desired for the planning and oversight of the Lake County behavioral health community.

## DOCUMENTATION RESEARCH

### OBSERVATIONS FROM SPECIFIC DOCUMENTS

The *Live Well Community Health Improvement Plan 2016-2021* is a five-year plan focused on implementation of interventions to address four identified public health priorities: cardiovascular disease and hypertension, obesity, behavioral health, and diabetes.

As it relates to behavioral health, the *Live Well Community Health Improvement Plan 2016-2021* outcome objectives were:

- Reduce the percent of youth who report feeling so sad or hopeless almost every day for two weeks or more in a row that stopped them from doing some usual activities by 10% from 28% to 25% by 2021;
- Reduce the average annual count of all emergency room visits due to mental health diagnoses by 10% from 12,453 per year to 11,208 per year by 2021; and
- Reduce the proportion of adults who report having a day or more in the past month where their mental health status prevented them from carrying on usual activities by 10% from 14% to 13% by 2021.

Further, the *Live Well Community Health Improvement Plan 2016-2021* dovetails on the strategies outlined in the prior report *Community Action Plan for Behavioral Health in Lake County, Illinois (2016-202)* to improve the behavioral health capacity and infrastructure in Lake County. Finally, the *Live Well Community Health Improvement Plan 2016-2021* identifies the following potential evidenced-based interventions to implement:

- Expand the use of telepsychiatry;
- Integrate primary care into behavioral health;
- Develop school-based behavioral health services to increase access to services for youth; and
- Design and implement a public awareness campaign.

The plan implementation is overseen by a Steering Committee and there are Action Teams developed to address each of the planned interventions. The Live Well Lake County website has updates for each of the initiatives including behavioral health capacity.

**Opportunity Related to Data Sharing Project:** As the Current Data Sharing Assessment is conducted and future data sharing facilitated discussions occur throughout the project, it can be explored to see if data, that is specific to these strategies and also in alignment with the information needed by the Lake County behavioral health community for planning and oversight, could be collected.

The **Community Health Status Assessment** (CHSA) report contains the quantitative indicators necessary for the community health improvement planning process. The report contains demographic and socioeconomic characteristics of the population that lives in Lake County.

**Opportunity Related to Data Sharing Project:** The Lake County demographic and socioeconomic indicators within this report will be helpful to use in comparative nature to data collected from the Lake County behavioral health community (e.g. access to services by demographic groups).

## DOCUMENTATION RESEARCH

### OBSERVATIONS FROM SPECIFIC DOCUMENTS

The *Behavioral Health Information* (October 2016) document prepared by the Lake County Health Department outlines several behavioral health definitions such as mental illness, serious mental illness, and behavioral health. Further, the document compares behavioral health statistics between the United States, Illinois, and Lake County such as:

- Persons with a mental illness jailed;
- Prevalence of persons with a serious mental illness;
- Prevalence by disorder;
- Mental Illness prevalence; and
- Substance abuse issue prevalence.

**Opportunity Related to Data Sharing Project:** There were some instances of not having the aforementioned data for Lake County. Future collection of data could include some of these measures for Lake County (e.g. access to care for those with a particular disorder such as depression or bi-polar; or prevalence of individuals booked into the Lake County jail that have a behavioral health need).

The *ServicePoint Demo for Mental Health Coalition* presentation provided an introduction to ServicePoint, an electronic application used by human service providers within Lake County for multiple purposes. The presentation provides an overview of the tool including:

- Features of ServicePoint:
  - Client management database
  - Web-based system
  - Track demographics
  - Make referrals
  - Run reports
- Use of ServicePoint in Lake County for
  - Making referrals between providers on the system
  - Used to fulfill the HUD grant requirements
  - Currently, 24 different Lake County Human Services Organizations use ServicePoint.

The *ServicePoint Quick Guide and Screenshots* document outlines the different types of data points collected within ServicePoint.

**Opportunity Related to Data Sharing Project:** ServicePoint is an example of where data sharing is actively occurring within Lake County for service coordination and aggregated reporting. ServicePoint can serve as a resource and the Lake County behavioral health community can incorporate lessons learned and strengths of ServicePoint as the future data sharing model is developed.

## DOCUMENTATION RESEARCH

### OBSERVATIONS FROM SPECIFIC DOCUMENTS

The following documents provide information as it relates to criminal activity, jail bookings, and future diversion guides within Lake County.

- The **Jail Population Report** (9.20.16) provides information about Lake County Jail's Average Daily and Peak Population 2013-2016 as well as the Annual Increased Costs from Jail Population Increase. It demonstrates that County Jail data can be provided at a summary level.
- The **Cases Filings Report** (01.04.17) provides the court cases filed from 1995 thru 2015 by case type (e.g. civil, criminal, family).
- The **Prison Utilization & Recidivism of Those Sentenced in Lake County** presentation prepared by the Loyola University's Center for Criminal Justice Research, Policy & Practice for the Executive Justice Council of Lake County contains many crime, arrests and court data using data from the 1980's through 2015, including the following:
  - Trends in Crimes Reported to the Police in Lake County
  - Trends in Arrests Made by the Police in Lake County
  - Trends in Drug-Law Violations Arrests in Lake County
  - Trends in Felony Filings in Illinois' Circuit Courts
  - Number of Convicted Felons to Prison vs Probation, Lake County
  - Percent of Convicted Felons to Prison, by Region of Illinois
- The **Lake County Jail Diversion & Health Engagement Project Implementation Guide** (December 31, 2016) prepared by Community Oriented Correctional Health Services describes a county-wide planning effort to develop a Jail Diversion and Health Engagement Project. The goals of this project were to 1) increase the number of individuals in Lake County with a serious mental illness who are diverted from custody, 2) reduce recidivism among individuals with serious mental illness in the criminal justice system, and 3) Improve mental health service access and continuity of care for justice-involved or likely to be justice-involved individuals with serious mental illness. Recommendations included three main components: a central drop off center; training to better recognize and respond to mental health issues in the community; and mobile crisis response.

**Opportunity Related to Data Sharing Project:** These types of reports can be used to explore if crime and jail bookings in Lake County reduce overtime. However, there is an opportunity to collect data regarding the behavioral health needs of individuals who interact with all law enforcement to identify needs as well as determine if recidivism for those with behavioral health needs reduces across law enforcement services.

## DOCUMENTATION RESEARCH

### OBSERVATIONS FROM SPECIFIC DOCUMENTS

There are many documents that provide information about the various organizations that serve individuals and families in Lake County or surrounding area. Following are several examples:

- The ***DuPage County Community Health Center (DCCHC) Tour on March 10, 2016*** flier provides a description and details for the DuPage County Community Health Center (DCCHC).
- ***The Alliance of Human Services – A Survey of Mental Health Resources in the Non-Profit Sector in Lake County, IL*** presentation document provides an introduction to the Alliance, its mission, vision, members, clients served, services offered, and their challenges.
- The ***Advocate Illinois Masonic Medical Center - Emergency Room Diversion “Dr. Halsted” Program*** whereby individuals with mental health begin their emergency room visit at a different entrance and are triaged at specialized locations for substance abuse and mental health.
- The ***Expanding Access to Care in Lake County: Erie HealthReach Waukegan Health Center*** presentation outlines services they provide, where people come from for their services, their healthcare partners (which includes LCHD as well as other Coalition organizations, and their integrated health approach, which includes both behavioral and oral health.
- The ***NorthShore University HealthSystem Highland Park Hospital*** (February 2017) presentation provides information on the inpatient psychiatric center providing services for adolescent and Young Adults.
- The ***Vista’s Behavioral Health Program*** (February 13, 2017) presentation provides information on the inpatient and outpatient services provided for adults and youth.

***Opportunity Related to Data Sharing Project:*** There are many programs throughout Lake County that are providing behavioral health services to individuals and families. All behavioral health providers should be invited to participate in the data sharing initiatives.

## DOCUMENTATION RESEARCH OVERARCHING THEMES ACROSS DOCUMENTATION

The following are overarching themes based on the documents analyzed regarding the Lake County behavioral health community:

- There are multiple initiatives underway focused on enhancing the behavioral health delivery system for Lake County. These initiatives include coordinating care for the overall population, specialized programs, and addressing unique population needs such as those involved in the justice system.
- There have been several evaluations conducted to understand the current state of the delivery system and develop recommendations, such as the year-long initiative in 2014 which concluded in the report titled *An Assessment of Behavioral Health Needs, Service Capacities, and Projected Trends in Northern Lake County*. Several initiatives and strategic plans were developed in response to these evaluations, including additional studies specifically focused on behavioral health. One such example is that upon release from jail individuals with mental health needs ran out of medications due to the long wait time to see a psychiatrist. The Lake County behavioral health community responded to this need by developing a program with the Health Department dedicates resources specifically for release inmates to offset the consequences of long wait times.
- The behavioral health community has come together to strategize around the needs surfaced by these evaluations which have also highlighted the need for an on going program to continuously provide recent information and data for planning and oversight purposes.
- There are multi-year strategic initiatives underway, involving many stakeholders and addressing topics that are common to communities throughout the nation, including recidivism, care coordination, and service capacity. However, there are also some initiatives that are not outlined in the plans that are part of the on-going dialogue related to community priorities. For example, one strategic plan does not include strategies to address expanded crisis services for individuals in high acute situations, or the needs of law enforcement and emergency rooms who interact with individuals needing behavioral health services.
- There are many “pockets of excellence” offering innovative approaches to provide services for individuals and families with behavioral health needs. Examples of this include, but are not limited to:
  - Implementing Mental Health First Aid training so members in the community can identify a behavioral health need and refer for services;
  - Implementing Crisis Intervention Team (CIT) training for both sworn officers and other law enforcement staff;
  - Use of trauma-informed approaches (e.g. use of service facility dogs at the County’s Child Advocacy Center);
  - Implementing “A Way Out Program” to support individuals with substance abuse challenges to ask for and receive help;
  - Incorporating behavioral health strategies into the county’s Live Well Lake County initiative;
  - Utilizing human service provider associations to create partnerships and support provider learning opportunities.

## DOCUMENTATION RESEARCH OPPORTUNITIES FOR DATA SHARING

The following are observations related to the opportunities for data sharing based on the documents reviewed regarding the Lake County behavioral health community:

- There were several initiatives and/or pilots that required or had goals of sharing data between service organizations for the purpose of coordinating care on behalf of behavioral health individuals and for aggregating data for planning and oversight purposes. These initiatives and/or pilots, such as those featured in this report, were exceptional in their purpose and design. The Coalition has much to learn from these initiatives for process development to expand to the larger population of individual and families. However, there remain some unanswered questions as to the sustainability and broader use and application of the practices and technologies employed for an on-going program (e.g. do the technologies meet requirements for HIPAA and HITECH).
- The activities and evaluations intended to understand the current state of the delivery system were informative however, they provided a snapshot in time view and do not and were not intended to convey the status of operations over time to identify trends or improvements. Examples include the highly cited *An Assessment of Behavioral Health Needs, Service Capacities, and Projected Trends in Northern Lake County* and hospitals' health needs assessments.
- There was a noticeable lack of documents available that outline service performance expectations, such as service process measures intended to assess the performance of a provider, or outcome benchmarks and goals, such as improved life living measures (e.g. home living status, employment status, daily skills). This information will be needed for an on-going program to help evaluate trends within the Lake County behavioral health community.
- Although a few documents cited some aspects of data sharing between service providers, no reports were found articulating information about the technologies used to collect or share information between providers with the exception of ServicePoint. Further, although some reports recommended data sharing, none of the reports or materials outlined any specific tactical plans for data sharing or the current process and mediums of data transfer across system partners.

## 3.1.2 NATIONAL AND LOCAL TRENDS IMPACTING BEHAVIORAL HEALTH

### NATIONAL HEALTHCARE TRENDS

Research and analysis were conducted to explore national healthcare trends/concepts that impact how services are organized and delivered within Lake County's behavioral health community. It should be noted that these concepts are becoming or are common knowledge within the current national healthcare landscape. An internet search of these topics will provide a plethora of information on the topic.

**Triple Aim** – The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance. The new designs must be developed to simultaneously pursue three dimensions, which are called the “Triple Aim”:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of healthcare.



**Integrated Care** – Integrated care focuses on more coordinated and integrated forms of care provision with the goal of having all care needs seamlessly provided to a patient including inpatient, outpatient, and behavioral health services. Within the United States, there is a growing trend to integrate physical and behavioral healthcare.

**Whole Healthcare** – Whole healthcare focuses on addressing the physical, behavioral and social needs of an individual.

**Managed Care** – Managed care is a healthcare delivery system organized to manage cost, utilization, and quality.

**Managed Care Organizations (MCO)** – Managed Care Organizations are business entities engaged in the management of healthcare delivery systems usually organized to address specific insured populations (e.g. Medicaid, Medicare, private insurance). Historically MCOs focused on cost containment. Current indications are that MCOs focus on all aspects of achieving the Triple Aim, not just cost containment.

**Person Centered Care** – Person-centered care is a way of thinking about and practicing clinical care that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure needs are met.

**Value-Based Care Delivery Models** – Value-based care delivery models use payment methodologies that incentivize cost efficiencies and improved outcome. These models are a move away from traditional fee-for-service that incentive volume to payment models that incentivize value.

## NATIONAL HEALTHCARE TRENDS

**Interoperability** – In healthcare, interoperability is the ability of different information technology systems and software applications to communicate, exchange data, and use the information that has been exchanged. As the need to reduce costs and improve outcomes increases, more payors and providers understand the value of being able to share data between providers to coordinate and improve care as well as measure outcomes through aggregated data. Interoperability will eventually become the expectation of delivery care rather than optional participation. Healthcare systems are focused on making sure their internal systems seamlessly interact with one another, especially if 2 programs or modules within a program are used to store different pieces of health information. Efforts to streamline internal data may need to be completed prior to organizations participating in a data sharing model.

**Health Homes** – Health homes integrate physical health and behavioral healthcare by assigning a “home” or service provider/organization to take full accountability for the prevention and treatment of health conditions. Health homes are being reimbursed using new payment methodologies that include demonstrating improved outcomes. Many Medicaid contracts are now requiring the use of health homes.

**Population Health Management** – Population Health Management is a strategy being employed by healthcare systems (e.g. health insurance plan, Accountable Care Organization, MCO) responsible for the overall care of a designated population. The responsible healthcare system uses data and analysis to ultimately improve care and reduce costs. Population Health Management strategies are becoming more and more sophisticated and the providers within these systems must also be accountable and utilize electronic systems for recording services and outcomes. The hospitals may be able to leverage their population health data, if it exists, in a future data sharing program.

**Business Competencies and Capabilities** – As the movement toward lean practices and improving efficiencies continues to expand, healthcare entities need to develop exceptional healthcare business competencies and capabilities. In some cases, organizations are banding together to share business competencies and capabilities allowing them to have access to skills not otherwise feasible and to realize savings through economies of scale. The types and amounts of shared and outsourced services are determined by the needs and gaps of the organizations participating in back-end shared operations.

**Risk Stratification** – Risk stratification has become more popular within physical health as a means to identify and categorize individuals’ needs. The same trend is apparent in behavioral health as providers attempt to assign risk scores to individuals to plot behavioral health individuals’ current and future progress along a continuum. The process of risk stratification can be adopted from other communities and providers or developed for the purposes of standardizing the processes within the Lake County behavioral health community.

**Mergers and Acquisitions** – Mergers and acquisitions (M&A) are business transactions in which the ownership of a company or operating unit is transferred to another company. M&As are becoming more commonplace in the behavioral health community to streamline operations within the new healthcare paradigms. Financial and operational efficiencies, such as contracting in a value-based care environment, the ability to obtain and utilize technology, are gained when smaller providers join forces with another. This trend can be seen locally with the Vista initiative with United Health.

## NATIONAL BEHAVIORAL HEALTHCARE TRENDS

A summary of national behavioral healthcare trends/concepts that impact how services are organized and delivered within the Lake County behavioral health community is provided below.

**Application of Healthcare Strategies within Behavioral Health Systems** – All of the aforementioned national healthcare trends are being adopted within behavioral health communities.

**Community-based Services** – Behavioral health communities are developing the service continuum to focus on services that meet the person where they are in the community rather than facility based. Lake County is geographically diverse and understanding through population and service statistics where individuals are receiving care can help identify service opportunities across the County.

**Support Services** – Behavioral health communities are expanding support services to include peer and family support, health promotion, living skills, employment services, housing support, home care, personal care, respite, and transportation. These support services provide greater access to care and alternatives to traditional medical treatment to care for the whole needs of the patient.

**Crisis Services** – Behavioral health communities are expanding crisis services to include coordinated care through formal agreements and technology, crisis call command centers, community-based mobile crisis teams, and crisis walk-in offices that can accept individuals with mild to acute crisis needs. Additionally, communities and providers are improving crisis episode follow-up services via phone calls, community response, peer/family support and appointments with on-going service providers. The Lake County health department offers some crisis services, and juxtaposing the services offered with best practices can provide insight into opportunities for expanded services to meet the needs of individuals with behavioral health.

**Peer and Family Support Services** – Behavioral health communities are expanding services to include peer and family support, which is an evidence-based behavioral health model of care, which consists of trained, qualified, experienced peer or family support person focusing on assisting patient needs. These services can be used in multiple ways – as a preventive or intervention approach, interventions to change behavior before a crisis, or during and after a crisis intervention. These services have formal CPT and ICD-10-PCS codes that can be used for insurance reimbursement. As care systems move treating the whole person, incorporating CPT and ICD-10 codes for services related to behavioral health will be critical to capturing the full patient story.

## NATIONAL CRISIS SERVICES TRENDS

Over the past decade, there has been a growing movement to expand the knowledge and implementation of effective crisis response services. There are many publications, conferences, websites and organizations that address the topic of crisis services. Community partners utilize these resources to divert individuals from jails and from emergency department use.

The table below reflects the advanced approaches to offering crisis services and these approaches are recognized as best practices and advocated for by experts in the field of crisis center care. The second column conveys the essential characteristics of the particular crisis service. The third column conveys the types of data being collected and used to assess the responsiveness of crisis services. This last column represents the type of data that could be shared across providers to improve care and outcomes.

Lake County's crisis center has been anecdotally discussed as having the opportunity to better meet the needs of the community and comparing its offerings to best practices could highlight any gaps in services or opportunities for improvement, such as greater awareness of the crisis line.

Type of Crisis Service	Essential Characteristics	Data Collected (Examples)
Crisis Call Command Center 	<ul style="list-style-type: none"> <li>▪ 24/7</li> <li>▪ Electronic Command and Control Center, facilitating access to care</li> <li>▪ Support for law enforcement and Emergency Departments</li> </ul>	<ul style="list-style-type: none"> <li>▪ Call volume</li> <li>▪ Average Speed of Answer (ASA)</li> <li>▪ Call purpose</li> <li>▪ Acuity scores</li> <li>▪ Number of requests from law enforcements or emergency departments</li> <li>▪ Call Disposition</li> </ul>
Mobile Crisis Team 	<ul style="list-style-type: none"> <li>▪ Meets individual or family in their home or other preferred location</li> <li>▪ Rapid response for law enforcement and Emergency Departments</li> <li>▪ Transport to Crisis Center, if needed</li> <li>▪ Electronic access to information</li> </ul>	<ul style="list-style-type: none"> <li>▪ Dispatch volume</li> <li>▪ Average response time</li> <li>▪ Response purpose</li> <li>▪ Acuity scores</li> <li>▪ Call Disposition</li> <li>▪ Payor source</li> </ul>
Crisis Walk In Centers 	<ul style="list-style-type: none"> <li>▪ 24/7 walk-in capacity</li> <li>▪ Accepts all crisis needs, including high acuity patients</li> <li>▪ 24/7 law enforcement access, with rapid drop-off turn arounds</li> <li>▪ Quick access to high levels of care, as needed</li> </ul>	<ul style="list-style-type: none"> <li>▪ Type of need</li> <li>▪ Acuity scores</li> <li>▪ Number of drop offs by law enforcement</li> <li>▪ Number of emergency department transfers</li> <li>▪ Average length of time to seen</li> <li>▪ Average length of stay</li> <li>▪ Disposition</li> <li>▪ Payor Source</li> </ul>

## STATE TRENDS

**Illinois Health and Human Services (HHS) Transformation** – In January 2015, the State of Illinois embarked on an HHS Transformation as a call to action of Illinois state agencies to better collaborate with one another to find solutions to complex human services issues utilizing a holistic approach. HS Transformation efforts began in 2016 with the intention of moving forward with strategies over one to two years.

### Guiding Principles

The HHS Transformation Guiding Principles are:

- Create a consumer-centric system: all programs, policies, processes, and technologies place individuals and families at the center
- Modernize service delivery: offer the people of Illinois the evidence-based support they need when they need it and in the communities and settings best suited to them
- Pay for outcomes and value: expect evidence-based practices in service delivery that moves from fee-for-service to value-based payment
- Organize to deliver: ensure a strong, streamlined organization, coordinated operations and a workforce skilled to serve the people of Illinois with the right care at the right place, at the right time, and at the right cost.

### Pain Points

It was determined that the focus of the HHS Transformation activities would be related to behavioral health. As the HHS Transformation leadership examined the behavioral health landscape, the system was evaluated through an understanding of the Illinois citizens served by behavioral health. This evaluation identified six critical pain points:

- Lack of coordination of behavioral health services around the customer
- System failures to identify and access those with the greatest needs
- Lack of community capacity for behavioral health services
- Limited set of complementary services
- Duplication and gaps in behavioral health services across agencies
- Data, analytics, and transparency limitations

# STATE TRENDS

## Illinois Health and Human Services (HHS) Transformation

### Actions Moving Forward

The Illinois Department of Healthcare and Family Services, the State's Medicaid agency, has moved forward with plans to transform its Medicaid system. Transformation efforts began in 2016 with the intention of moving forward with strategies over 1-2 years. The state will be expanding the use of managed care to address unsustainable and escalating program costs and improve care for individuals through an integrated care approach. Excerpts from the January 9, 2017, Illinois HHS Medicaid Waiver Advisory Committee are contained in the Appendix section as *Appendix 6. Excerpts from the Illinois HHS Medicaid Waiver Advisory Committee Discussion*. These excerpts provide more context around the HHS Transformation initiative that is in alignment with efforts of the Coalition.

Strategies being employed towards these transformation plans include:

- Amend how the state operates its Medicaid plan by applying for a 1115 Demonstration Waiver from the Centers for Medicare and Medicaid Services (CMS). A 1115 Demonstration Waiver will allow the state to be exempt from some of the standard Medicaid requirements and use exploratory ways to pay for and improve care. In essence, the state's 1115 waiver application focuses to have integrated care and address the behavioral health needs of its members. The waiver application can be read on the Illinois Department of Healthcare and Family Services website.
- The state issued an RFP for Medicaid Managed Care Organizations (MCOs) and have made contract awards to several organizations. These contract are in effect beginning January 1, 2018. The following MCOs will operate statewide:
  - Blue Cross and Blue Shield of Illinois
  - Harmony Health Plan
  - IlliniCare Health Plan (also covers children in the custody of the Illinois Department of Children and Family Services)
  - Molina Healthcare of Illinois
  - Meridian Health
  - CountyCare, a health plan run by the Cook County Health and Hospitals System, that will operate in Cook County only.

The HHS transformation has appointed the Illinois Medicaid Advisory Committee. This committee is tasked with making recommendations about the management and operations of the Medicaid program. They have adopted a ten point Medicaid behavioral health strategy and are weighing in on topics such as the implementation of:

- Health homes;
- Person-centered care approaches;
- Criteria for enrollment into care management for individuals and families with high needs;
- Technology and data submission requirements;
- Potential approaches to support capacity development, infrastructure development; and
- Incentives for value-based payment models.

## LOCAL TRENDS

**911 Center Operations Consolidation** – A 911 consolidation initiative is underway to explore and plan for consolidating disparate 911 center operations across Lake County. This initiative offers collaborative opportunities with the behavioral health data sharing initiative to gain agreement on data collection and standardization to inform planning and oversight tasks for the behavioral health community.

**Live Well Lake County** - Live Well Lake County has a Steering Committee made up of representatives from community-based organizations, government agencies, healthcare systems, and academic institutions. The purpose of the committee is to guide community health assessment processes, prioritize community issues, and collaborate to improve the overall health and well-being of residents in Lake County. The Live Well Lake County initiative collects data and tracks progress around 12 priorities including behavioral health.

**Mental Health Coalitions Website:** The Lake County Mental Health Coalition's existence and website is a step forward toward coordinated care and increased awareness for services available. The Coalitions diverse representations charter encompass representatives from all aspects of the behavioral health community and its charges as outlined in the Charter each include driving large scale projects to produce real results. The Mental Health Coalition website can also serve as a go-to resource for community to learn about the service providers available which can increase the access to services.

### 3.1.3 COMPARABLE DATA SHARING MODELS FROM OTHER COMMUNITIES

Data sharing models from comparable communities were researched and analyzed in the manner outlined in section 2. *Research Approach*. The information on the following pages is the product of conducting the research which included conducting interviews.

The comparable data sharing communities that were researched and reported on in the following include:

- Live Well San Diego, San Diego, California
- Familiar Faces, King County, Washington
- Community Care Management Network, Louisville, Kentucky
- Multiple Programs, Johnson County, Kansas
- NurseWise, Southern Arizona
- Behavioral Health Link, Georgia
- Camden Health Information Exchange (HIE) and Camden Arise, Camden, New Jersey

The following types of information are reported on the following pages for each comparable data sharing community researched :

- Summary of the community initiative;
- Highlights about:
  - Data inputs;
  - Sponsorship team;
  - Sectors/ players sharing data;
  - Technology use;
  - Governance structure;
  - Data points/measurements available;
- Programs and benefits enabling the data sharing
- Key differentiators;
- Rationale for selecting the comparable data sharing community for research for this project;
- Purpose and origins of the data sharing initiative;
- Methodologies and tools used for the data sharing initiative;
- Funding sources for the data sharing initiative; and
- Other available information such as diagrams, dashboards.

## COMPARABLE COMMUNITY MODELS SELECTION RATIONALE

**These comparable communities were selected given the variety of technology used for data sharing and their applicability within Lake County under Illinois Law.** The programs ranged from sharing aggregated data through spreadsheets and measuring broader health metrics across the population to complex hybrid systems with new businesses developing and serving as a central repository for missing information. What is apparent across all of these examples is the considerable amount of time these initiatives take as well as how many require the organizations to be part of the program to provide a lens into the population needs system-wide. Additionally, each program has evolved over the years to address data sharing barriers and adapt to the needs and demands of the population it serves.

**San Diego** – Based on research and correspondence with the program, participating organizations in this data sharing program submit aggregated data via spreadsheet. This is a compliant, basic way to start data sharing that could work for the Lake County behavioral health community. Because the metrics are aggregated, the legal barriers are largely driven by each organization’s policies around sharing aggregated data. Functionally, San Diego is similar to the Coalition in that unaffiliated entities came together to collect and use data to determine if they were improving the health of a community, just as the Coalition similarly is trying to use data to improve the health and care of individuals with behavioral health needs.

**King County** – From a legal perspective, this program like many others, started with the publicly available data from the justice system, which the Coalition has similar access. This county started with identifying participants with four or more bookings, which is similar to data that the Coalition has access to in Lake County. Functionally, the King County patient-centered future vision illustrates the “no wrong door” policy stressed in the Coalition’s charter. This community demonstrates how a cross-system collaboration can result in developing a bold vision for cross-system data sharing and then develop a phased approach to moving towards that vision. One key difference to learn from King County is that the county acts as the Medicaid MCO for behavioral health and as such owns the claims data for Medicaid beneficiaries. Claims data is a crucial data set for participant-level data sharing and as Illinois has recently identified the MCOs that can serve Lake County, the Coalition should begin to work with the MCOs to gain access to this data to benefit the individuals with behavioral health needs in Lake County.

**Louisville** – This program also began with publicly available data and through more casual recognition of familiar faces, began to focus on high utilizers. The Coalition has access to similar public booking information and the Lake County behavioral health community also uses the Service Point application as a central repository. Since the information is included in a central repository to which other programs have access, Louisville has a common release of information form. If the Coalition were to adopt a similar program, the consent to release form would also need to include the stipulations outlined in 740 ILCS 110 and Service Point would need to have the capability to track each of those 9 aspects by person as well as the release signature.

## COMPARABLE COMMUNITY MODELS SELECTION RATIONALE

**Johnson County** – This program also started by using publicly available booking data and booking information which is also available under Illinois law. Data points available include name, case number, date, case type, nature of offense, charge, disposition, arresting agency, count, and court events. As the Lake County Jail creates its screening program, its law enforcement agency should decide whether having a non-licensed individual screen a patient for behavioral health needs allows them to be compliant with their HIPAA regulations and where this information could be stored so that it could be available upon discharge within the community with the appropriate releases. Johnson County serves as an example of how sharing even a couple of data points across service providers into a central repository can increase the speed of care coordination

**Nursewise** – The Nursewise model introduces a new service offering, an advanced crisis center, into the framework and the Lake County Health department offers some of the crisis services included in the Nursewise program such as a crisis clinic. Data is not routinely shared or sent to the Nursewise organization electronically, although information about the crisis incident can be collected over the phone. Nursewise serves as the care coordination quarterback, assisting individuals in navigating the network of behavioral health services to assist individuals in gaining access to the right services. As a result, Nursewise can share data with service providers for the purposes of providing services for an individual. A comparable to Nursewise in Illinois is the DuPage crisis center as it has some service provider partners co-located in the facility for the purposes of providing coordinated care.

Nursewise established operational protocols and standards to outline how cross-system partners work with a command center and crisis line. Through Nursewise's operations and the technology employed, the program collected new data, processed both urgent need requests and records data, and aggregated this data into operating reports distributed to system partners. Similar advanced reporting in for the Lake County behavioral health community would formalize elements of a data sharing model and were provided here for the purposes of introducing additional capabilities that could help meet the Lake County behavioral health community's data sharing needs.

**Georgia Behavioral Health Link** – This information was made possible through a state-wide initiative, which Illinois has not mandated, although their strategy and vision for data sharing is in alignment with the Illinois strategy. However, the aggregated data presented by the Georgia behavioral health link dashboard could be calculated using aggregated metrics as reported by Lake County pursuant to the participating organizations' internal policies. The dashboard itself also presents a consistent report of metrics that provide insights into the raw data files submitted to the central repository. This report helps members of the community to make decisions, which is the same overarching goal in Lake County.

**Camden** – Camden serves as the best in class in data sharing and is a good example of how functionally all programs evolve over time. Camden also illustrates the hybrid model technology requirements and that hospital data can be limited only to organizations and approved individuals.

# SAN DIEGO, CALIFORNIA

## LIVE WELL SAN DIEGO

“Live Well San Diego” is a collection of otherwise **unaffiliated entities**, anchored by the County Board of Supervisors, of many disparate community organizations aiming to improve the health, safety, and quality of life of San Diego residents by sharing knowledge and best practices. Their **aim is not behavioral health-specific but rather to improve quality of life as measured by ten metrics** contributing to an estimated 50% of deaths in San Diego County.



### Programs and Benefits Enabled:

- *The 3-4-50 study*, which surfaced that three issues leading to four diseases lead to 50% of deaths, gave rise to the 10 health and wellness metrics the county elected to pursue.
- Breadth of partnerships allows for large scale marketing for community events such as a 5K

### Key Enablers and Differentiators:

- No HIPAA-protected information is shared- low barriers and risk
- More than 120 organizations contribute to the breadth of information in monthly summit-style meetings

# SAN DIEGO, CALIFORNIA

## LIVE WELL SAN DIEGO

### Rationale for Selecting Comparable

- The purpose of conveying information about this comparable model is to illustrate how a community with unaffiliated entities came together to collect and use data to determine if they were improving the health of a community. Lake County similarly is trying to use data to know information about a population

### Purpose and Origins

- Live Well San Diego has some of its origins in the 3-4-50 study. This study found three behaviors led to four diseases which resulted in more than 50% of the deaths in San Diego County. This study began in 2008 and the service was launched in 2010 to start a 10-year initiative to decrease the prevalence of those three behaviors. To measure the program's progress, Live Well San Diego created 10 community health benchmarks.
- Those ten health benchmarks are: life expectancy, crimes per 100,000 people, % of days with unhealthy air quality, unemployment rate, (% of population) living independently, with a high school diploma, spending less than 1/3 of income on housing, living within 1/2 mile of a park, have experienced food insecurity, and who volunteer.

### Methodologies and Tools

- Live Well San Diego is a collection of 120+ organizations in and around San Diego. This partnership is anchored by the County Board of Supervisors and San Diego Behavioral Health Services. These organizations gather at summits to share knowledge and best practices to contribute to general population health and, specifically, to the 10 identified health factors. At these summits, information is passed between organizations in a more informal manner.
- Without sharing personally identifiable information, these organizations see little need for significant governance measures as they circumvent HIPAA by not sharing detailed or protected information. This is carried out by only sharing aggregated or anecdotal information.

### Funding

- Funding sources include: Beacon Communities – \$1.7 million, Bridges to Employment in Healthcare – \$25 million, Communities Putting Prevention to Work – \$17.9 million, Community Nutrition Expansion Project – \$700,000, Low Income Health Program – \$50 million, Community Transformation Grant – \$15.3 million, Public Health Infrastructure Grant – \$350,000, SNAP Participation Grant – \$900,000.

Sources include: [Livewellsd.org](http://Livewellsd.org), [sandiegocounty.gov](http://sandiegocounty.gov), [cuyamaca.edu/services/health/live-well-san-diego.aspx](http://cuyamaca.edu/services/health/live-well-san-diego.aspx), [healthinfo.org](http://healthinfo.org), Email exchange with Office of Strategy and Innovation for Live Well San Diego

### Key Observations Enabling the Solution

- The community has implemented a low-tech solution, the use of Excel spreadsheets. This solution can be leveraged in other communities, such as Lake County, to get started with a data sharing program as Excel is well known across organizations.
- There is no HIPAA-protected information shared lowering barriers and risk.
- The data standardization process and data governance required prior to starting to sharing data was minimal as the calculation of the metrics are simpler, such as a count of service provided or number of patients seen.
- Very inclusive engaging over 120 organizations.- The low barriers to participation allow a high volume of organizations to contribute. With a diverse network of community behavioral health providers, a low tech solution for aggregated data could enable more organizations to participate.
- Does not allow for identification or analysis of individuals given that participant-level data is not provided. Several grants and initiatives in the past have focused on the top utilizers within Lake County as a priority for care coordination and without individual level data a data sharing model with only aggregate level data can not answer questions on high utilizers.
- Data included does not expand beyond healthcare – does not include justice or law enforcement data. As surfaced during the Current Data Sharing Assessment interview process (see section 3.2 *Current Data Sharing Assessment*), diversion from jails and emergency departments is a priority within the Lake County behavioral health community. The Lake County behavioral health community would need to incorporate justice information to make this model more useful for their purposes.

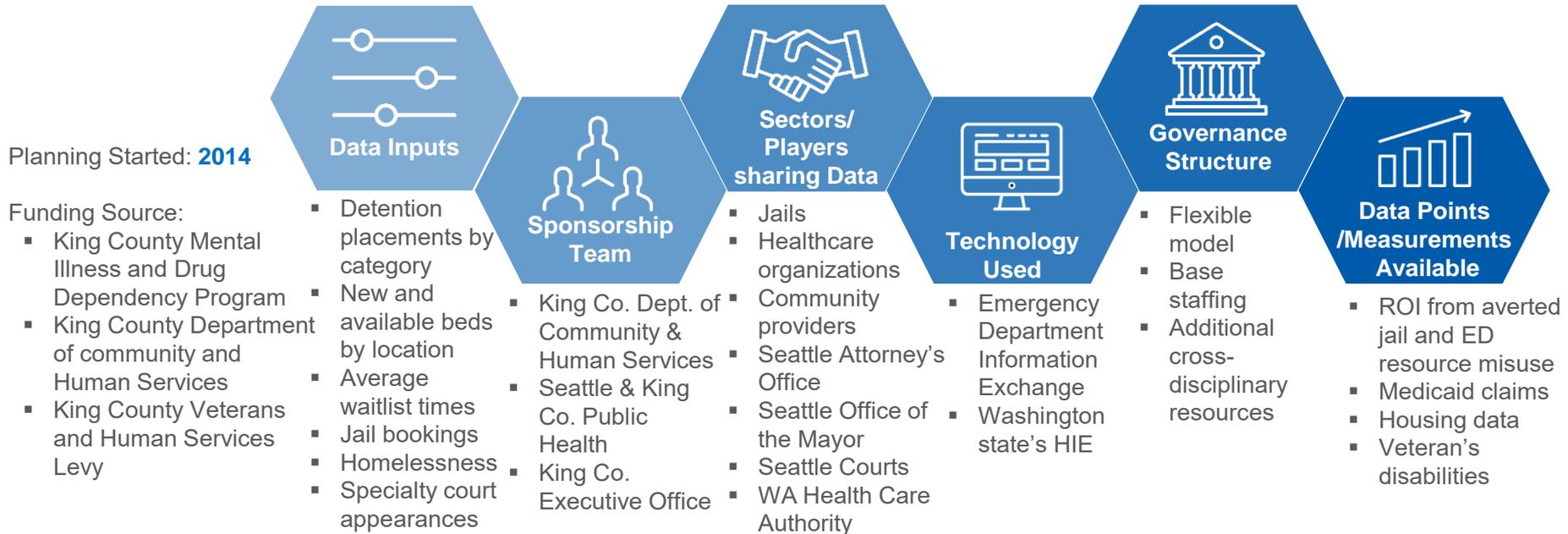
### Live Well San Diego Data Dashboard

  <span style="float: right;"></span>							
<i>Live Well San Diego Expanded Indicators</i> October 2016							
		 HEALTH	 KNOWLEDGE	 STANDARD OF LIVING	 COMMUNITY	 SOCIAL	
Indicator	Measure	We want to increase this		↑	San Diego	California	United States
		We want to decrease this		↓	Latest Year	Latest Year	Latest Year
<b>HEALTH - Enjoying good health and expecting to live a full life</b>							
Life Expectancy	Measure of length and duration of life expected at birth			↑	82.3 yrs (2013)	81.2 yrs (2012)	78.8 yrs (2013)
Cigarette Smoking	Percent of population who smoked cigarettes in the last 12 months			↓	16.5% (2016)	16.7% (2016)	20.5% (2016)
Exercise	Percent of population spending 2 or more hours exercising per week			↑	56% (2016)	53% (2016)	49.5% (2016)
Doctor Visits	Percent of population having visited a doctor in the last 12 months 6 or more times			↑	28.6% (2016)	27.8% (2016)	29.1% (2016)
Quality of Life	Percent of population that is sufficiently healthy to be able to live independently (not including those who reside in nursing homes or other institutions)			↑	94.9% (2014)	97% (2014)	96.9% (2014)
<b>KNOWLEDGE - Learning throughout the lifespan</b>							
Education: High School Diploma	Percent of population with a High School Diploma or equivalent			↑	85.2% (2014)	82.1% (2014)	86.9% (2014)
Less Than High School Diploma	Percent of population with less than a High School Diploma or equivalent			↓	14.8% (2014)	17.9% (2014)	13.1% (2014)
Bachelor's Degree or Equivalent	Percent of population with a Bachelor's Degree			↑	33.9% (2014)	31.7% (2014)	30.1% (2014)
Graduate or Professional Degree	Percent of population with a Graduate or Professional Degree			↑	12.9% (2014)	11.8% (2014)	11.4% (2014)
School Enrollment	Percent of combined gross enrollment of school aged population			↑	89.6% (2014)	90.4% (2014)	87.9% (2014)

# KING COUNTY, WASHINGTON

## FAMILIAR FACES

King County has established itself as a pioneer within the mental, emotional and behavioral healthcare coordination space. One program, “Familiar Faces,” acts as a system’s coordinator for healthcare, justice, and community organizations to identify and intervene on behalf of heavy consumers of King County’s jail and ED resources. The long-term goal is to improve outcomes and reduce costs via an integrated data system by diverting users to the appropriate care when its needed to avoid misuse of high acuity services.



### Programs and Benefits Enabled:

- Intensive Care Management Team provides comprehensive and integrated services for behavioral health adults
- Participation in state-wide Managed Care Organization
- Improved: health status and housing stability
- Reduced: criminal justice involvement, avoidable ED use, and population health disparities

### Key Differentiators:

- Used data matching to conclude 94% of all people with four or more jail bookings had a behavioral health indicator
- Has flexible staffing model in which only the minimum number of resources are staffed full-time but can be augmented during high volume periods

# KING COUNTY, WASHINGTON

## FAMILIAR FACES

### Rationale for Selecting Comparable

- The purpose of conveying information about this comparable model is to illustrate how a cross-system collaboration can result in developing a bold vision for cross-system data sharing and then develop a phased approach to moving towards that vision.

### Purpose and Origins

- Familiar Faces began as a jail diversion program to better understand top utilizers. It evolved into a data integration platform and is set to become a data set analysis. King County community services and public health leaders started by convening both a management guidance team from relevant organizations as well as a project design team. Work began in 2014, services began July 2016, and the hope is to reach the stated goal of shifting from a costly, crisis-oriented response to one that focuses on prevention, embraces recovery without population disparities by 2020.
- An initial data matching effort demonstrated 94% of individuals in the King County jail had a behavioral or substance use disorder. This high percentage created a consensus that something has to be done. The Familiar Faces program is similar to Lake County's effort to identify and better treat the highest 100 utilizers.

### Methodologies and Tools

- One tool, known as the Emergency Department Information Exchange (EDIE), is a proprietary data-sharing and real-time notification system currently being used by many healthcare providers in King County. The second system is the Washington State Health Care Authority's sponsored Health Information Exchange (HIE), known as Link4Health. King County already houses a range of client-level data including Medicaid claims, behavioral health, Veteran's, developmental disabilities, homeless services and housing data, county-provided employment services data, and county and municipal jail booking and release data.
- Data integration program enables individual client "lookup" for direct care coordination, identification of high-risk groups based on flexible criteria, system-level care coordination, extracting datasets based on flexible criteria, analysis of population health, and program evaluation and costs.

### Funding

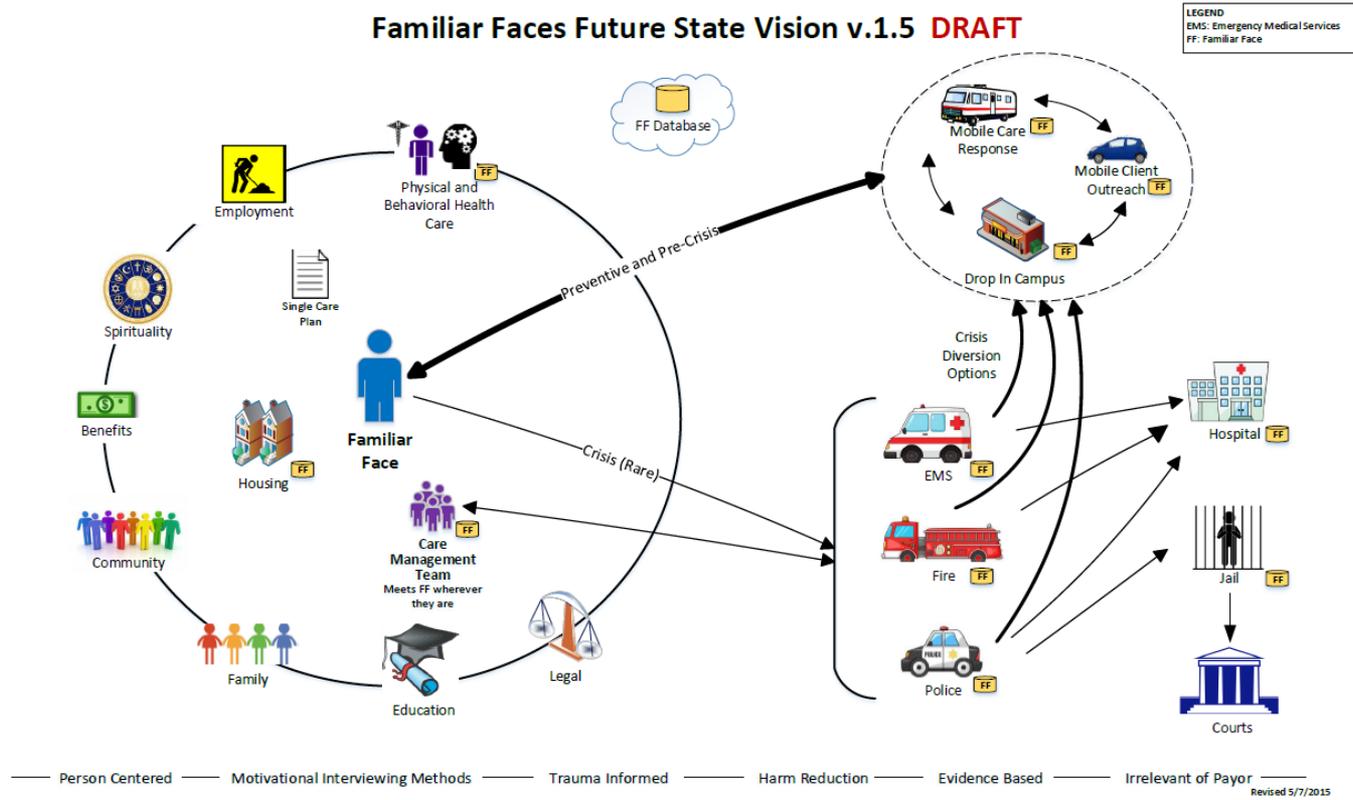
- Funding structures include King County Mental Illness and Drug Dependency and King County Department of Community and Human Services groups & King County Veterans and Human Services Levy.

Sources include: [http://www.naco.org/sites/default/files/event\\_attachments/Familiar%20Faces%20Brief.pdf](http://www.naco.org/sites/default/files/event_attachments/Familiar%20Faces%20Brief.pdf) , <http://www.naco.org/sites/default/files/documents/DDJ%20Playbook%20Discussion%20Draft%2012.1.16.pdf> , King County Health and Human Services Transformation The Familiar Faces Initiative June 2016 and updates, Washington State HIE snapshot, Evaluation of the State Health Information Exchange Cooperative Agreement Program, kingcounty.gov, bizjournals.com, qualishealth.org

# KING COUNTY, WASHINGTON

## FAMILIAR FACES

Familiar faces is one of King County's programs and the below diagram is a visual depiction of how the county wants to operationalize a person-centric model to improve a variety of outcomes.



**Participants include- 28 participating organizations across hospitals, healthcare centers, psychiatric centers, community organizations, care coordinators, homelessness groups, County Offices, Courts, Sheriff, and State Departments**

Source: <http://www.kingcounty.gov/elected/executive/health-human-services-transformation/familiar-faces.aspx>

### Background:

- Washington State Medicaid contracts with the counties to manage and contract for behavioral health services (however, this is moving to fully integrated MCOs – responsibility for both physical and behavioral health services).
- King County has had all the Medicaid claims and extensive data already within their county administrative system. For the Medicaid behavioral health population, they already know key data such as who is accessing care, how fast they are accessing care, and where they are accessing care.

### Familiar Faces has a Future Vision for Data Sharing (prior page)

### Familiar Faces has agreed upon several “Go-first strategies”

- Since King County owns some of the key data points, as a first step the county is integrating what they can within the various systems within County Departments (e.g. Medicaid, housing, employment)
- They are in a planning phase for the data warehouse that will integrate other stakeholders (e.g. first responders, courts)
- Implementing clinical best practices for addressing the needs of the justice involved (e.g. Care Management Team)

### Other information :

- They have had for many years a daily data feed from the jail to the Medicaid program in the county who then alerts behavioral health providers when one of their individuals has been booked into jail.

### Key Observations Enabling the Solution

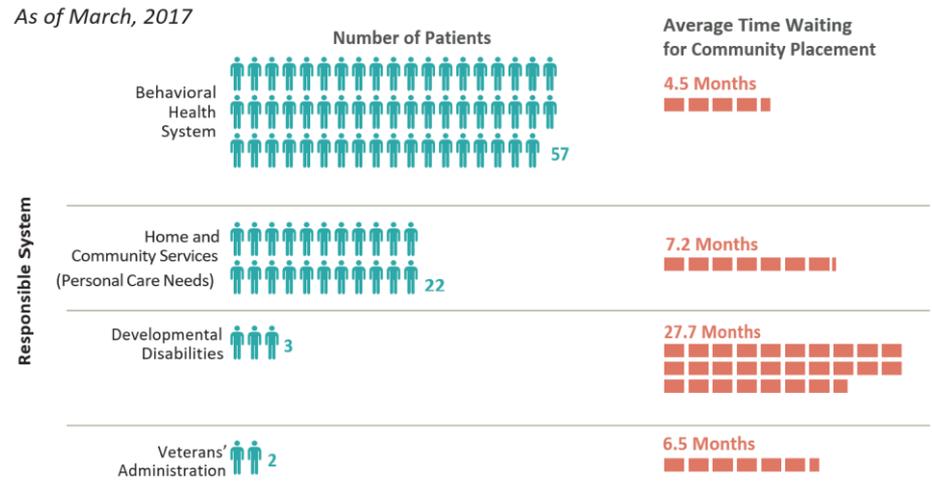
- King County is in the position of acting as the Medicaid MCO, thus, by virtue of their role they have access to all behavioral health claims for the county – allowing access to data to answer many of key questions needed for a behavioral health community. The Lake County Health Department does not serve as the Medicaid MCO and the Lake County behavioral health community would need to partner with hospitals or insurance companies for this information.
- The initial set of data involved was cross-sector, jail, and behavior health data. The King County model combined jail data for people with four or more bookings with behavioral health claims. This model did not include all individuals with behavioral health needs and if Lake County wants to understand the demand on the entire system, data would need to be shared on behalf of all individuals with behavioral health needs.
- The data matching has only been conducted once – has not been repeated. System partners within the Lake County behavioral health community done a similar participant mapping as a part of other initiatives, such as identifying high utilizers across organizations. However, to have a sustainable, on going data sharing model, this activity would need to be running behind the scenes as information is entered from any source to make sure not to duplicate information.
- The coalition agreed upon a future vision data sharing vision and several go first strategies that will move them towards the future vision. This vision provides them with the direction needed to move forward while allowing flexibility in the approach for moving forward given the complexities of building a data sharing model and coordinating care. The Go-First strategies operationalize immediate next steps for King County and translate abstract direction into tangible action to help move the county forward. A similar approach, could help the Lake County behavioral health community continue forward into Phase 2 of its data sharing initiative as it develops its implementation plan.

# KING COUNTY, WASHINGTON PSYCHIATRIC BOARDING PROGRAM REPORT

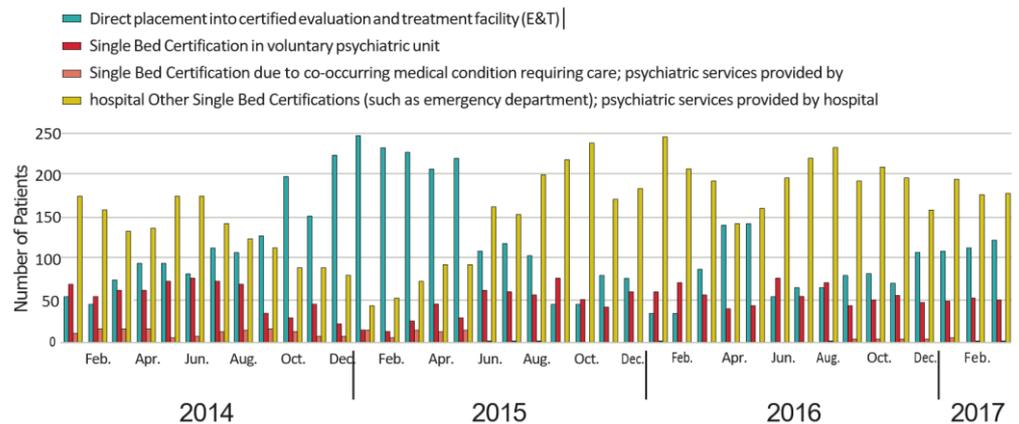
Among many reports and data outputs, the real-time and consolidated data collection efforts King County can produce reports to outline the following:

- Number of patients across the responsible system
- Average time patents within each system need to wait for community placement
- Utilization of crisis psychiatric services
- Hospital bed utilization
- Number of patients waiting for a group home
- Average waiting time for a group home
- Openings at group homes
- Patients waiting for supported housing
- Average time waiting for supportive housing
- Openings for supportive housing
- Average number of days on the wait list for state hospitals
- Access to King County evaluation and treatment beds for acute care patients by short term and long term orders
- Availability beds from select hospitals
- Estimated number of new evaluation and treatment beds

## King County Patients Ready for Discharge from Western State Hospital (WSH) As of March, 2017



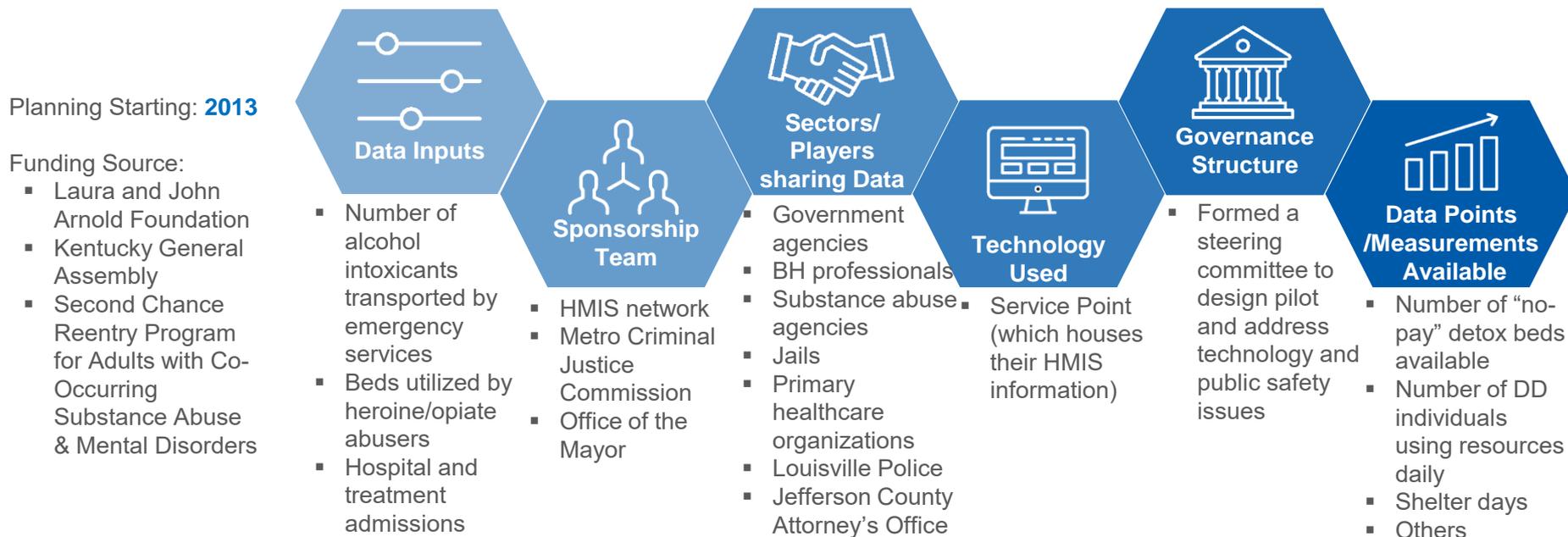
## King County Crisis and Commitment Services Detention Placements by Category



# LOUISVILLE, KENTUCKY

## COMMUNITY CARE MANAGEMENT NETWORK

The Dual Diagnosis Cross Functional Team (DDCFT) is a collaboration of government agencies, behavioral health professional, and community organizations that came together to create the Community Care Management Network- a coordinated case management super-system. The Community Care management Network (CCMN) taps into existing systems rather than having to be “hard fed” as more traditional systems do.



### Programs and Benefits Enabled:

- Reduction of: number of jail admissions and bed days, shelter days, emergency service runs, inpatient psychiatric admissions, percent homeless, in-custody detox, number of ED visits

### Key Differentiators:

- Ubiquitous use of HMIS allows CCMN to retrieve information more easily
- Common MOU and information releases ease the burden of legal compliance for all involved organizations

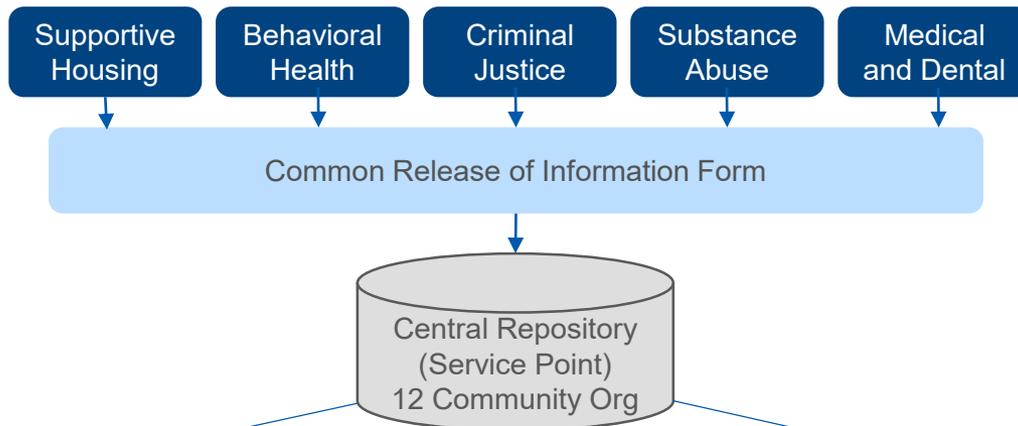
# LOUISVILLE, KENTUCKY

## COMMUNITY CARE MANAGEMENT NETWORK

Below is a comparison of the Louisville and Lake County's' current use of Service Point. Lake County could leverage Service Point similar to Louisville by expanding the referral source into the program or owning some of the data input to track more individuals and collect additional data points.

### Community Care Management Network Data Process Flow

1. Participant or high utilizer is referred from one of these entities for systemic case management
2. Ask that a release of information be signed
3. Release of information and patient name uploaded into Service Point
4. Ancillary information entered into service point
5. 12 participating organizations track those participants



### Outcome Measures

- Reduction in the number of jail admissions and bed days
- Reduction in shelter days
- Increase in mental health/substance abuse treatment retention
- Reduction in numbers of Louisville Metro Emergency Medical System runs
- Reduction in percent homeless
- Reduction in number of inpatient psychiatric admissions and hospital days
- Increased in number of ACA/Medicaid enrollments
- Reduction in the in custody detox population
- Reduction in the number of emergency department visits

72.

### Lake County Service Point

Several community organizations leverage Service Point to track select information on participants. It serves as the central repository for homelessness information and complements a variety of other internal systems for data within the organizations that use the program. Service Point does hold data from other sectors and is looking to expand its current use.

#### Organizations currently enter the following data:

1. Household Size
2. Where Housed/Sheltered
3. Homeless Service Treatment Providers
4. Vulnerability Index
5. Sources/amount of Income
6. Primary Care Provider
7. Required Data Fields ( name, Gender, Ethnicity, Cell, Birth Date, Race, SSN, Veteran Status)

### Aggregated Data

Number of Homeless individuals  
 Number of Unsheltered Homeless  
 Number of First Time homeless  
 Number with Increase Income  
 Average Time Homeless  
 From where enter homelessness  
 To where exit homelessness  
 Housing Stability  
 Who is homeless (Families, Veterans, people with disabling condition)

### Rationale for Selecting Comparable

- The purpose of conveying information about this comparable model is to illustrate how one community has used Service Point in an alternative way than how Service Point is used within the Lake County behavioral health community.

### Purpose and Origins

- The impetus for this initiative came from the mayor with the initial focus on individuals with co-occurring disorders. This initial call to action group included the HMIS network and the Metro Criminal Justice Commission.
- Louisville-Jefferson County Metro, Ky., developed a cadre of community partners to share information and pursue innovative solutions to identify, coordinate and deliver care to individuals who frequently use public services. This collaboration, known as the Dual Diagnosis Cross Functional Team (DDCFT), is composed of government agencies, behavioral health professionals and community organizations serving people with behavioral illnesses and substance abuse disorders. HIPAA regulations prohibit community providers from sharing this data with the jail but the jail is free to share names and dates of birth with the provider, putting the onus on the provider to do the analysis.
- It took approximately four years from the time of the first study to going "live."

### Methodologies and Tools

- The DDCFT is a cross-sector collaboration formed to create a case management super-system with its own "select sharing agreement." This body created the Community Care Management Network (CCMN) which is the community-facing, active arm of the DDCFT and acts as the case management system.
- Significant features include common MOU and release of information documentation and all participants' utilization of HMIS/Service Point.
- The DDCFT utilizes the Homeless Management Information System (HMIS) as the backbone for the new network, which is comprised of the participating community organizations. The HMIS system is operated statewide by the Kentucky Housing Corporation and coordinated locally by the Coalition for the Homeless. The system employs Service Point Software for case management and tracking purposes and will support the information sharing and case management needs of participating network agencies with only minor modifications. Using the HMIS, participating organizations can view and track individuals as they encounter other organizations in the CCMN. (<https://louisvilleky.gov/government/criminal-justice-commission/dual-diagnosis-cross-functional-team>)

### Funding

- Funding comes from grants from Laura and John Arnold Foundation, Kentucky General Assembly, and the Second Chance Act Reentry Program.

73 Sources include: <https://louisvilleky.gov/government/criminal-justice-commission/dual-diagnosis-cross-functional-team>, <http://www.naco.org/articles/what-about-data>, Montgomery County Community Health Assessment And Community Health Improvement Plan 2016-2019, [healthinfolaw.org](http://healthinfolaw.org), and the Louisville Metro Government Dual Diagnosis Cross-Functional Team 2<sup>nd</sup> Annual Report-out Session.

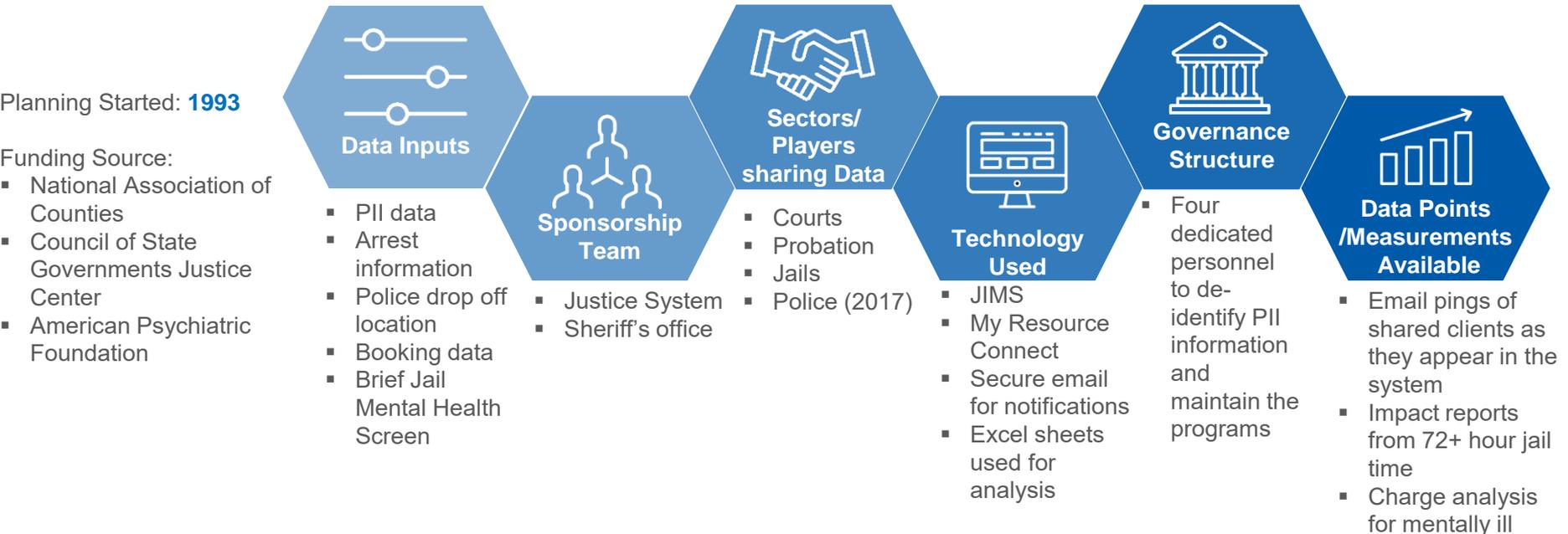
### Key Observations Enabling the Solution

- The community uses Service Point as central repository solution for sharing data. The Lake County behavioral health community also uses Service Point and is concurrently evaluating its expanded use, which could include data points collected in the Louisville Metro County, pursuant to compliance approval.
- This community has developed protocols for assessing individuals who are booked into jail to determine if the individual has behavioral health needs, and if so, provide expedient referral to care upon transition back to the community. The Lake County Jail has a similar initiative underway to implement a screening process to identify behavioral health needs and using this model to understand how that can translate into a transition back to the community can assist the individuals in jail with receiving services in the community.
- Formal procedures have been established to obtain a consent to release information to support recording and sharing of data electronically. A similar release of information, leveraging the release of information in place today with Service Point, could be agreed to and developed on behalf of participating organizations to streamline the operations supporting a data sharing program.
- Funding comes from various sources including private funding. As the Lake County behavioral health community determines a more detailed plan to implementing the desire data sharing model, it should research public and private funding options to support the implementation and maintenance of a data sharing model.
- The community is able to report on cross-system data. Similar to the desire within the Lake County behavioral health community to capture data from healthcare organizations, the justice system and community organizations, the Louisville model collects and stores information as entered by organizations in each of these sectors.

# JOHNSON COUNTY, KANSAS

## MULTIPLE PROGRAMS

The Johnson County program exemplifies the power that a single system, improved coordination, and early detection can have on individuals' overall health. Johnson County "Stepping Up" began with all partners in the justice system using their Justice Information Management System (JIMS) program and later building a tracking tool called My Resource Connect. This tool receives a few pieces of identifiable information, de-identifies the information and stores it within a central repository that then notifies organizations of a shared client to improve care coordination. This effort has resulted in several data-driven programs and services.



### Programs and Benefits Enabled:

- Several longitudinal and multiple factor statistical analysis, i.e. Charges for behavioral health population
- Program in which care coordinators call recently released individuals to assess needs and connect them to services to improve chances of success and lower recidivism

### Key Differentiators:

- All participating organizations use JIMS- Justice Information Management System
- Quicker identification of shared patients improves timely access to services
- Brief Jail Mental Health Screen quickly identifies those with severe behavioral health needs

### Rationale for Selecting Comparable

- The purpose of conveying information about this comparable model is to illustrate how a justice community has been successful in 1) developing reports across time to understand the overall behavioral health service need and 2) developing programs to identify behavioral health needs and connect individuals care expeditiously.

### Purpose and Origins

- Johnson County joined the “Stepping Up” program to address over-incarceration of the vulnerable, mentally ill population. Washington DC, Miami FL, and Sacramento CA were also part of the pilot. However, for Johnson City’s purposes, this initiative has its roots in 1993 when the court systems implemented JIMS.
- Johnson County enjoys a strong sponsorship team consisting of the National Association of Counties, Council of State Governments Justice Center, American Psychiatric Foundation and the Justice System chief operating officer. The Sheriff’s Department encountered barriers to adoption and was the last to subscribe.

### Methodologies and Tools

- Johnson County built a new tool to pull in data from JIMS (Court System) and other entities and surface it through another customized program- My Resource Connect.
- JIMS houses all court data. Participants receive notifications if a shared client has encounters across the system. Select identifiable data points are sent and then de-identified on the back end, after a universal identifier is provided.
- Hospitals are not included, nor are 42 CFR organizations. This initiative is compliant with HIPAA through log-in and access rights in My Resource Connect.
- A Brief Mental Health Screen is to be conducted within 72 hours of booking which also provides additional data for reference and analyzation.
- My Resource Connect is managed by a team of four individuals responsible for patient data de-identification. Additionally, the initiative partners with programs, universities, or other organizations for additional analysis resources.
- Data collected has helped to understand trends for the mentally ill inmate population and identify areas of intervention, such as a program where care coordinators reach out to individuals within 24 hours of release.

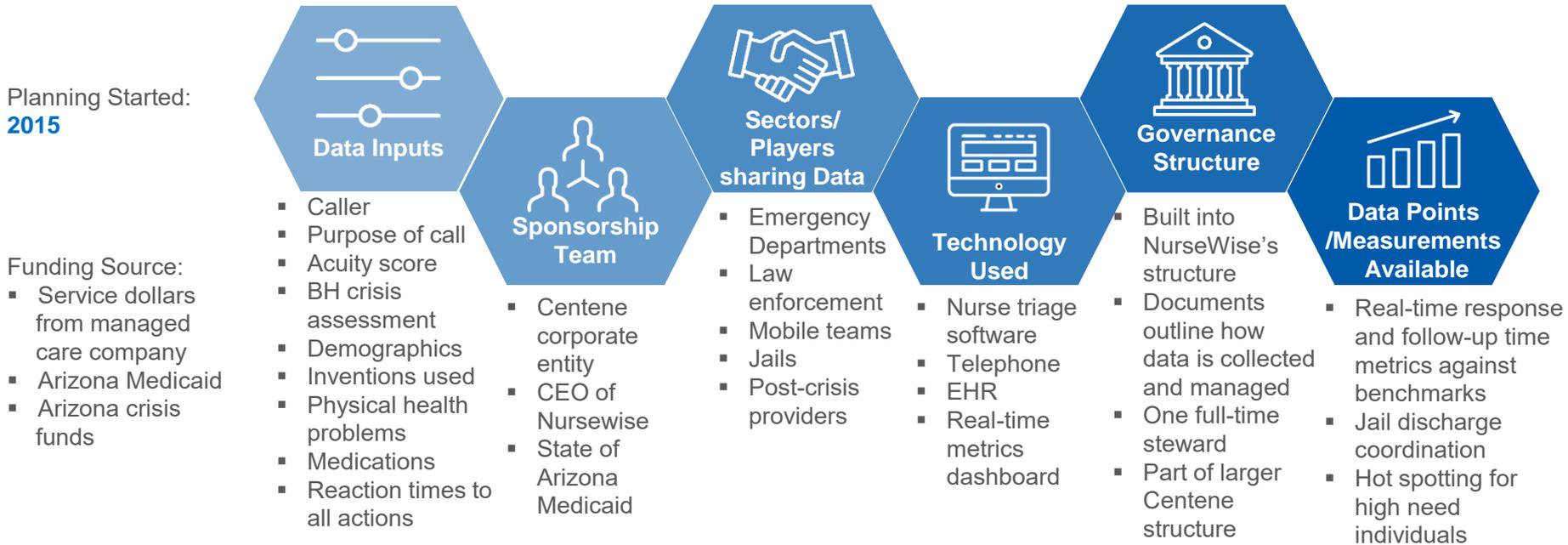
### Funding

- Funding structures include the National Association of Counties, the Council of State Governments Justice Center and the American Psychiatric Foundation.

### **Key Observations Enabling the Solution**

- The data sharing initiative started as a justice sector effort and has expanded to be cross-sector. The Lake County behavioral health community could also start a data sharing program by using publicly available booking information.
- Some entities are not included in the Johnson County data sharing initiative such as hospitals and entities that are obligated to 42 CFR regulations. The single system that allows data sharing within the Johnson County Justice System was used by all justice partners and custom built to meet their needs. While the Lake County court system has a custom built solution, not all law enforcement agencies use the program and has such a large data standardization effort would need to take place to share data across the five Computer Aided Dispatch (CAD) systems prior to combining data with the Lake County court information.
- The community has been successful in reporting trends over time allowing data sharing initiative stakeholders to identify successes and continued opportunities for improvement. This is made possible through participant level data which accounts for services or incidents rendered to the same individual and thus the data is cleaner. The Lake County behavioral health community wants to build a sustainable data sharing program and as a result will also be able to conduct longitudinal analysis in time. The quality and insights from that analysis will be strongest if individual data is shared.

The Arizona State Medicaid program requires in its contacts with managed care organizations to utilize innovative approaches to improve outcomes, reduce costs and be responsive to individual/families and system partners. The Centene Corporation has the contract in Southern Arizona and has instituted the use of a “command and control center” through NurseWise for facilitating access to urgent and routine care. The call management system and electronic health record were developed to facilitate access and capture data for system reporting.



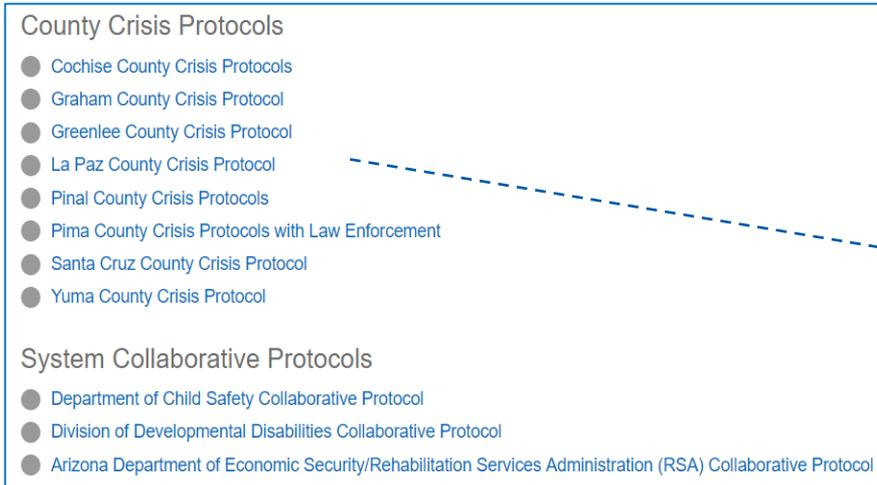
**Programs and Benefits Enabled:**

- Ability to track data such as call and response times against contractual requirements in real-time
- Geo-map capabilities to identify mobile crisis team with shortest response time, real-time transmission of clinical data to mobile team
- Centralized scheduling for urgent and routine appts to community providers

**Key Differentiators:**

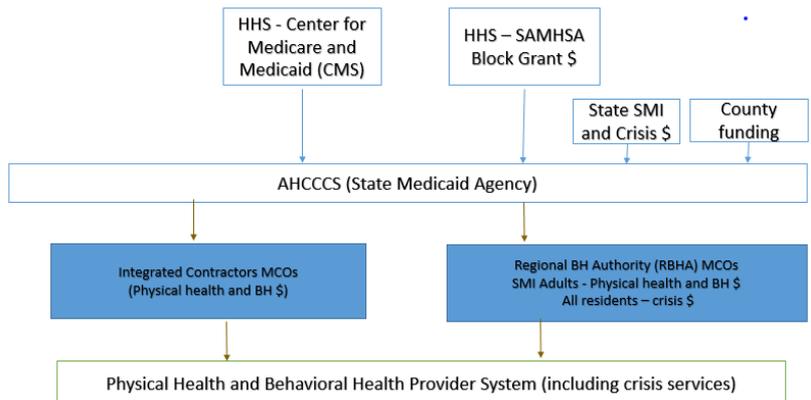
- Acts a central hub connecting in-crisis individuals to mobile teams, available crisis beds, and follow-up providers
- Protocols for addressing needs of emergency departments, law enforcement, jails, child protective services established – specific data points collected and reported on – e.g. number of referrals and timeliness and outcome/dispositions

The eight counties within Southern Arizona agreed upon their own protocols and standards across a host of services and partnered with system collaboratives, such as the department of children safety and development disabilities, to establish system-wide goals. These protocols also outline tribal agreements and approve providers.



- Protocols include, but are not limited to the following:
- Key definitions for crisis
  - Relationship with law enforcement and interactions while on site
  - Crisis line availability
  - Mobile team territories within each county
  - Warm Lines
  - Critical Incident Stress Management involvement,
  - Relationship with and/or interaction in the Jail or Detention center
  - Emergency admissions into behavioral health inpatient facilities
  - Assistance in emergency rooms as needed

## Funding and Sources



- Sources include: AHCCCS's Building a Health Care System: Care Coordination and Integration, <https://www.cenpatointegratedcareaz.com/inthecommunity/crisis-intervention-services.html>, <https://www.cenpatointegratedcareaz.com/inthecommunity/system-partner-resources.html>, <https://www.cenpatointegratedcareaz.com/inthecommunity/system-partner-resources.html>

### Rationale for Selecting Comparable

- The purpose of conveying information about this comparable model is to illustrate how one community is using a central repository approach in a non-traditional way. Operational protocols outline how cross-system partners work and coordinate with a command and control crisis center who in turn facilitates access to care. Further, the command and control crisis center records all transactions and creates operating reports that are shared with system partners.

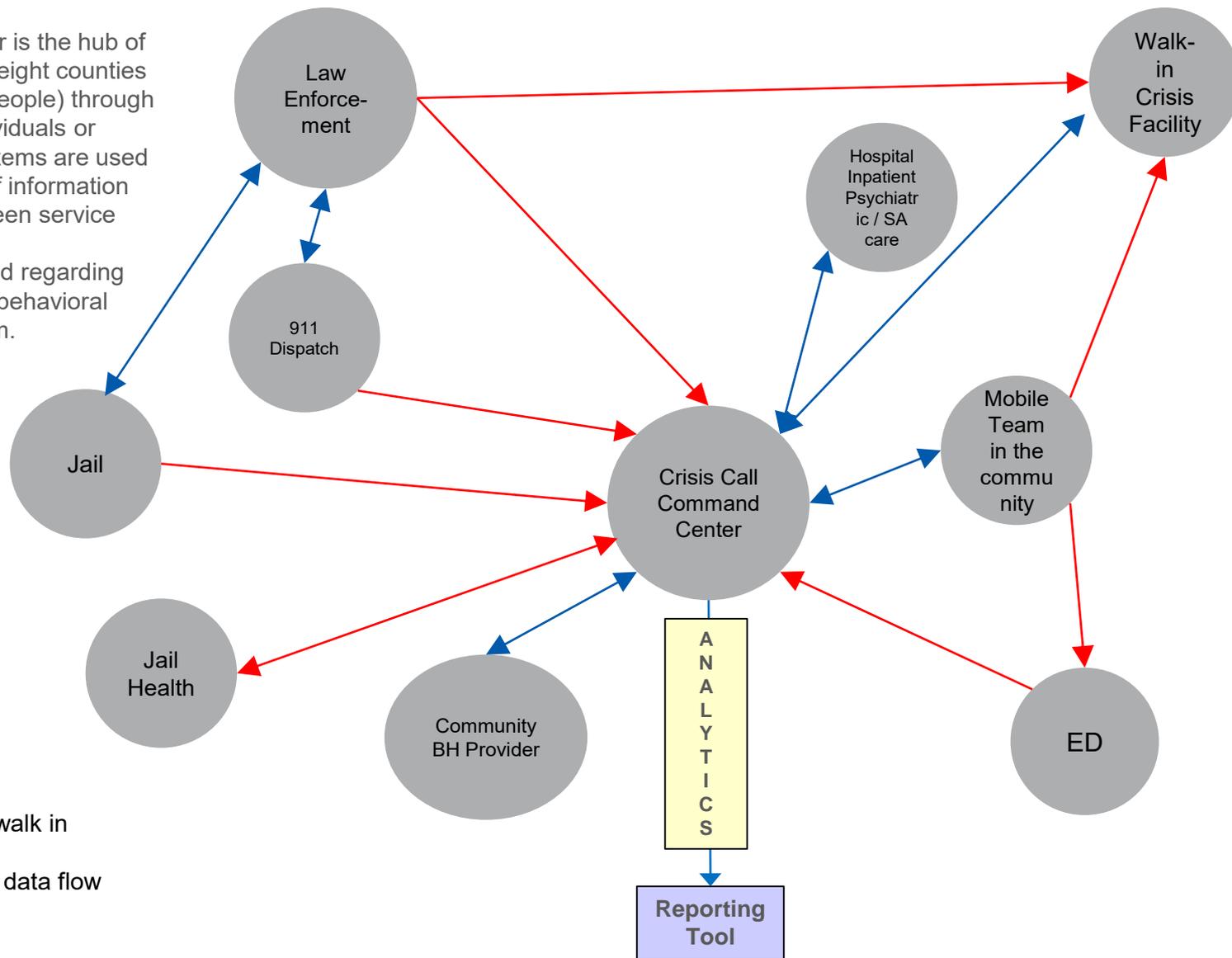
### Purpose and Origins

- NurseWise is the single crisis line for all of southern Arizona and functions as the information hub for that geography.
- Medicaid is forcing health plans to be more responsive to cost efficiencies and outcomes, which drives health plans to be more responsive to people in crisis, child welfare, justice, and those with high service needs.

### Methodologies and Tools

- NurseWise, which acts as a central hub between mobile teams and law enforcement, is capable of real-time exchange with the mobile teams as their electronic medical record (EMR) is connected to the mobile teams' mobile phones. Police calls are prioritized, using the same dispatch technology from the mobile team system. After assignments are made, pings are sent to mobile phones. If a mobile team is on site for a significant period of time the dispatcher is pinged. The mobile teams submit information about care, acuity, next steps, and disposition. The goal is to leave the individual in the community.
- Mobile teams and crisis staff have access to online scheduling for service providers (centralized scheduling) for urgent and routine care by community behavioral health providers.
- Process flow: calls come in, data is captured, call management system and EMR put out real-time information, daily reports from prior day generated. These reports include volume, timeliness against metrics, and the exception report.
- HIPAA allows for coordination with crisis call centers. Law enforcement can share information with Nursewise who can then transmit it to the mobile teams.
- Arizona's Statewide HIE has a 2-year plan to connect all hospitals, community health providers, and behavioral health providers. NurseWise is participating in that plan to share crisis data and receive other data.
- There are plans to transition some of the daily reporting into dashboards for the community.

The Crisis Call Center is the hub of collecting data for all eight counties (roughly two million people) through phone calls from individuals or system partners. Systems are used to facilitate the flow of information and connection between service providers. Reports are developed regarding the operations of the behavioral health delivery system.



**KEY**

- Red – phone call or walk in
- Blue – data transfer
- Arrows – direction of data flow

### Key Observations Enabling the Solution

- This community demonstrates an alternative way to collect data and report data through a centralized crisis call command center, where data is entered into an EHR.
- In addition to collecting data into a centralized place, there are additional technologies for real-time data sharing with mobile teams based throughout a community/region and real-time scheduling of community-based behavioral health services (urgent and routine appointments). Currently no real time data sharing occurs between two system partners within the Lake County behavioral health community during the point of care.
- The operational process and technology application have been established in a way to overcome legal privacy barriers. Part of this process was establishing data sharing agreements as the system was being implemented.
- This community has developed standard operating protocols to standardize practice for care coordination between cross-system partners such as law enforcement, emergency rooms, child protective services, jails, courts, community behavioral health providers, and inpatient behavioral health providers. Similar efforts will be needed in Lake County to enable data sharing and ensure a data sharing model's sustainability.
- There are agreements between the centralized crisis call command center and system partners about data reporting is shared. While the Lake County behavioral health community is interested in setting up a new data sharing model, as opposed to a new crisis center, developing data sharing agreements can be a good way to gain buy in into a new program.
- The Nursewise technology solution is funded through service funding from Medicaid and state funding. As the Lake County behavioral health community focuses on next steps for the data sharing initiative, all potential sources of funding should be evaluated.
- Nursewise has plans for integrating into the statewide HIE application over the next few years. While Illinois HIE efforts were unsuccessful previously, data sharing is becoming increasingly popular and as new programs are established in the future Lake County can look for additional partnerships to fold into its data sharing model.

# GEORGIA

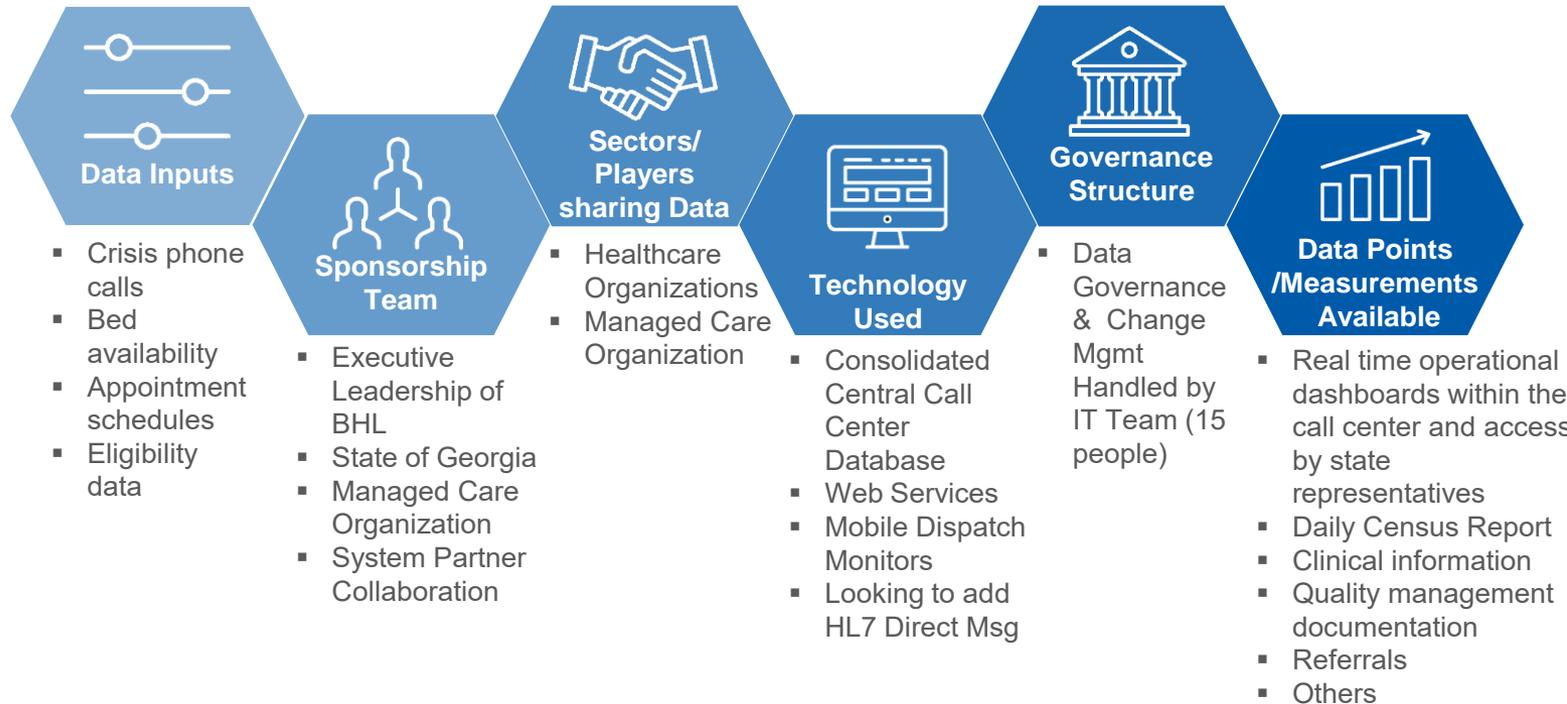
## BEHAVIORAL HEALTH LINK (BHL)

In 2006, BHL began a unique collaboration with the state of Georgia to form the *George Access and Crisis Line*, a single statewide crisis call center to facilitate access to routine care or help in a crisis. The collaborative is intended to serve individuals and families and be responsive to system partners such as law enforcement and hospital emergency departments. This program is well known for their real-time and incremental data /reports so there is statewide transparency of the service delivery system.

Planning Started: **1998**

Funding Source:

- Funding for the technology and reporting is obtained through their overall service funding.



### Programs and Benefits Enabled:

- Single number for access to care or help in a crisis
- Mobile clinicians assess more than 600 individuals per month at their residence, in the community (park, social service agency), in the emergency departments to disposition them to the community and meet with law enforcement in the street as needed

### Key Differentiators:

- Consolidated database with all necessary data
- Mobile teams are dispatched electronically
- Real-time operational dashboards
  - Mobile team availability, timeliness
  - Beds boards for inpatient / crisis care

# GEORGIA

## BEHAVIORAL HEALTH LINK (BHL)

### Rationale for Selecting Comparable

- The purpose of conveying information about this comparable model is to illustrate how one community is being progressive in using real-time data including use of bed boards to know the availability of crisis stabilization and inpatient beds as well as having information on the overall real-time operations of a crisis system. Further, select data elements are provided to the funder, the state, on a real-time basis.

### Purpose and Origins

- BHL was founded in Atlanta in 1998 when the county decided to model other successful ventures. The organization started with a single number for crisis care across Georgia Department of Behavioral Health & Development Disabilities. In 2005, it won its bid for the Georgia state-wide crisis hotline and web-based internet service.

### Methodologies and Tools

- BHL develops fully customizable software (in conjuncture with RI International) "to assist our call takers in managing the complexity of crisis calls while capturing vital information necessary to ensure we link individuals to the most appropriate care available." BHL then sells software packages/programs to other entities.
- The primary purpose of BHL's software tools is data collection. Their hallmarks are a customized build and a rapid-fire feedback mechanism during development. The implementation is the responsibility of the purchasing firm.
- The software is designed to capture crisis call center generated clinical information, quality management documentation, mobile crisis assessment data and to manage bi-directional, electronic referrals to outpatient services, mobile crisis teams, crisis stabilization units, and inpatient facilities. Additionally, the software tracks the progress of referrals and availability of resources in real-time and provides interactive dashboards and complex reporting solutions designed to measure the efficiency and the effectiveness of the process.
- The crisis center is staffed with social workers 24/7.

Sources- <https://riinternational.com/blog/georgia-crisis-access-line-10-years-later/>)

# GEORGIA BEHAVIORAL HEALTH LINK (BHL)

Behavioral Health Link is a real-time dashboard measuring key metrics on the response time and availability of resources across Georgia.

Key metrics include:

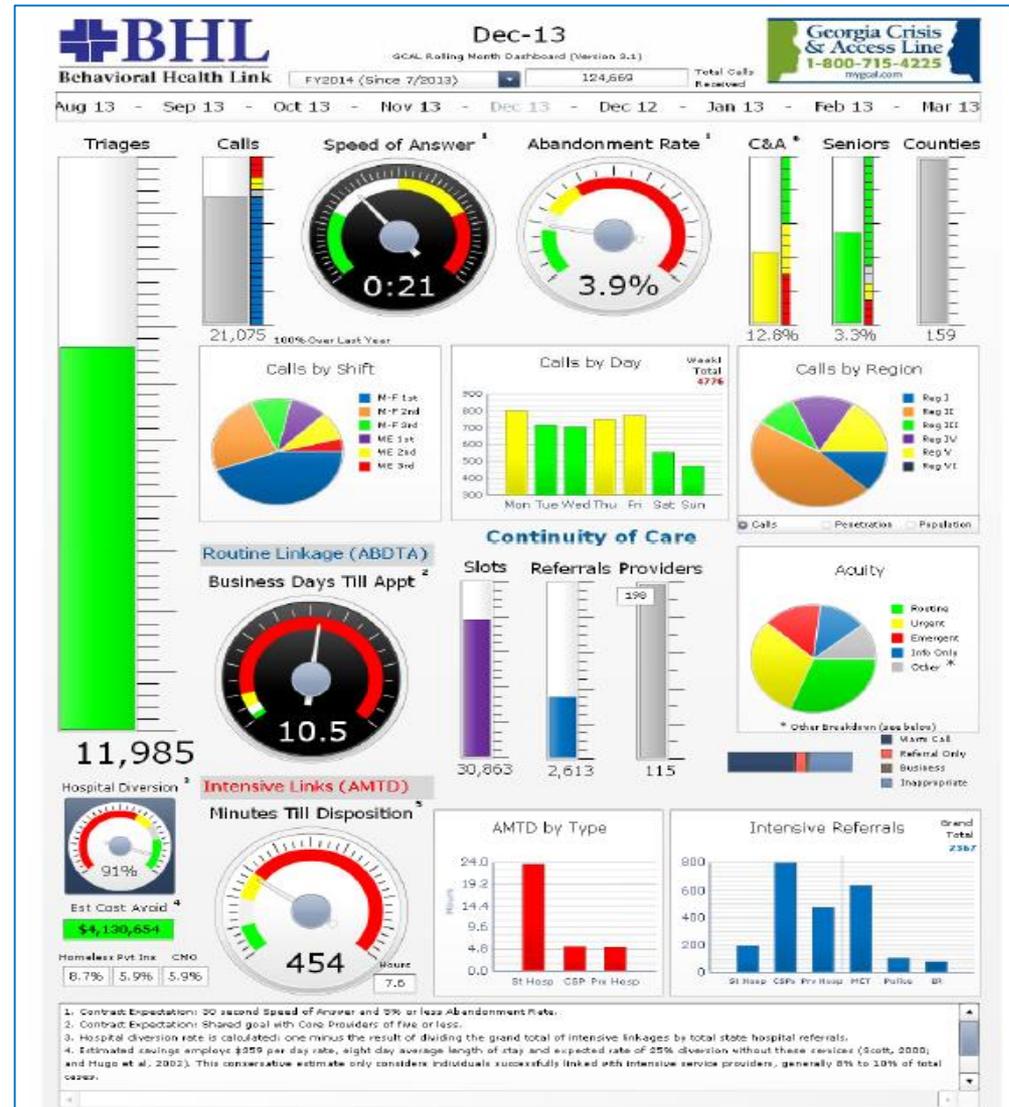
- Number of triages completed
- Number of calls by region
- Number of referrals
- Percentage of hospital diversion

Behavioral Health Link then provides reports on a monthly basis regarding their Call Center Operations and performance.

The state also has real-time access to the dashboard

Behavioral Health Link also provides a daily census report that includes the number of beds filled daily.

Example Monthly report



### **Key Observations Enabling the Solution**

- This community has established data collection and reporting processes that enable real-time dashboard applications that inform how the behavioral health system is performing regarding access to care and timeliness of care. This is an example of a live feed and more technically advanced solution that can assist with equipping users of the program with the information needed to provide individual access to service providers.
- This community started with some initial data collection priorities and has expanded over time to become more sophisticated in what data is collected and how information is reported and made available to system partners and funders of behavioral health services. In this same way, the future data sharing model for the Lake County behavioral health community should be given the flexibility to adapt and grow as new developments and needs of the model are surfaced.
- This community has incorporated clinical best practices into the design of clinical processes and technology applications to drive practice. The Lake County behavioral health community can leverage these, including the metrics displayed, for their reporting purposes if the reporting capability is desired by the Lake County behavioral health community.
- This community has embarked on some innovative approaches in collaborating with emergency medical services (EMS) such as having staff co-located with EMS.

# CAMDEN COALITION OF HEALTHCARE PROVIDERS

The Camden Coalition of Healthcare Providers has several models and initiatives for data sharing among its partners that have evolved over time:

## Camden Coalition Health Information Exchange (HIE) 2010

- Objective - Linking patient data across systems for improved care delivery. The Camden Coalition HIE is a web-based technology offering participating local and regional healthcare providers secure, real-time access to shared medical information.
- **Exchange of data is bi-directional**, facilitates sharing of detailed clinical data **among primarily healthcare organizations**: hospitals, physician practices, laboratory and radiology groups, and other healthcare organizations.
- Currently, there is **no exchange of data to non-healthcare organizations** – organizations are able to only view HIE data.

## Camden Administrative Records Integration for Service Excellence (ARISE) 2015

- Objective - Combines information from public data systems to create a multi-dimensional picture of citywide challenges. By linking information from multiple data systems, including criminal justice, healthcare, and housing, Camden ARISE can help drive better decisions about allocation of resources and address the root causes of recurring public problems.
- **Exchange of data is unidirectional**, project's first phase integrates data from the Camden County Police Department with claims data from regional hospitals to shed light on overlapping issues in healthcare and public safety.
- Analysis of the combined data will indicate strategic points of intervention that may reduce hospital readmissions, arrests, recidivism, and more.
- **This model does combine healthcare data with non-healthcare data.** Combines hospital claims data with police records.

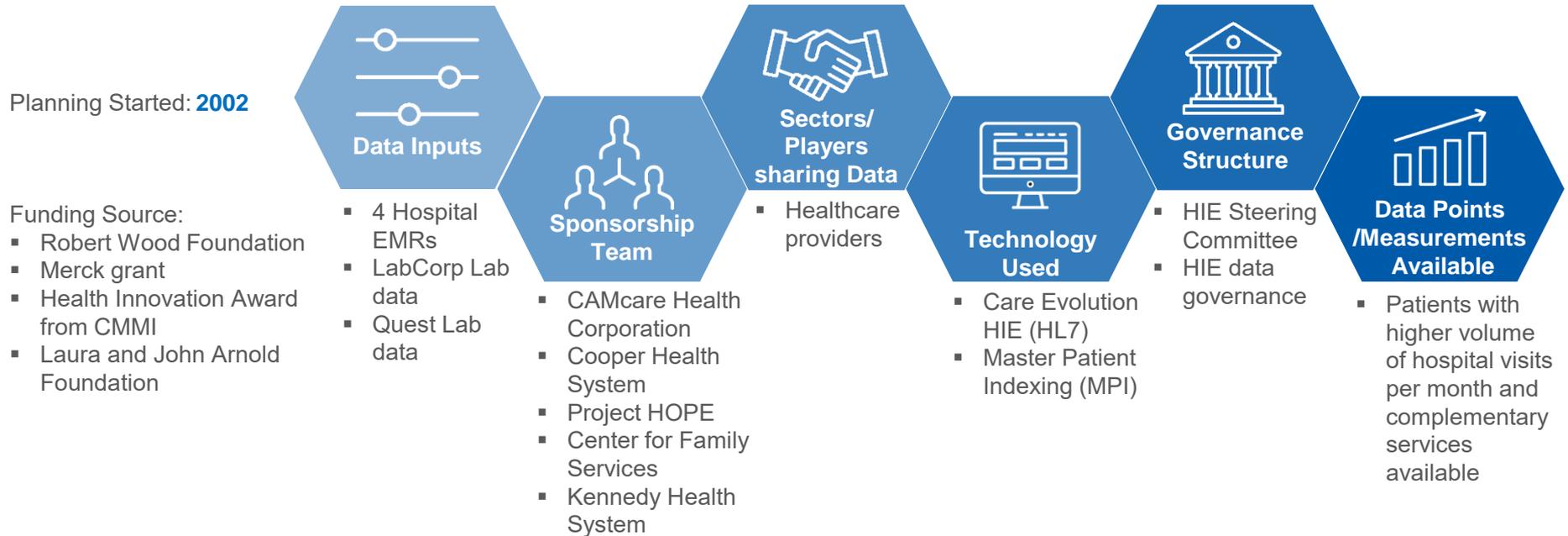
## Camden Behavioral Health Collaborative 2015

- Initially a hospital-based driven initiative.
- Objective –Identifying high utilizes of ED services across hospitals.
- **Exchange of data at this point is unidirectional**, hospitals shared five years of claims data to identify individuals with behavioral health needs that are high utilizers of ED services.
- Recently prioritized metrics they want for a dashboard.
- Currently building portal in the HIE to document behavioral healthcare plan for those who utilize ED services.
- Recently added community behavioral health services providers to the collaborative to start exploring how the interface with hospitals and community providers can address the needs of individuals.
- Note- they have interpreted that hospitals are not 42 CFR facilities and therefore share information for service coordination.

# CAMDEN, NEW JERSEY

## CAMDEN COALITION HIE

The Camden Coalition Health Information Exchange (HIE) aims to link primary healthcare providers in such a way as to allow bi-directional data exchanges of patient information. Nine hospitals and four local health organizations have partnered to create a robust data exchange specific for participating organizations, Non-healthcare organizations cannot exchange data at this point.



### Programs and Benefits Enabled:

- Healthcare organizations can share data bi-directionally
- Care Management Initiatives identifies patients with frequent hospital admissions for care coordination

### Key Differentiators:

- Detailed data sharing agreements to standardize onboarding additional contributors, aside from the hospitals and county police
- Extensive grant funding, most notably from Laura and John Arnold Foundation

### Rationale for Selecting Comparable

- The purpose of conveying information about this comparable model is to illustrate how one community is utilizing a very sophisticated approach to data sharing - health information exchange (HIE) resulting in advanced care coordination and advanced reporting capabilities.

### Purpose and Origins

- The founder, Dr. Jeffrey Brenner, had a regular patient with two terminal health issues who ended up in jail and Dr. Brenner was unable to get the patient's information to the appropriate entities at the jail.
- The Camden Coalition was founded in 2002 and launched the HIE in 2010.
- The program adds no money but holds the pilot programs out as examples to train others on how to run successful behavioral health diversionary programs and keep mentally ill people out of jail.

### Methodologies and Tools

- Live time basis HIE consolidating EMR information across four hospitals.

Updates made within the hospital send an automated change file via HL7 messaging with the specific data point that was deleted, changed, or added.

- Local hospital EMR is connected to the HIE and will scan the EMR for updates. If present, a doctor will receive a notification that updates are available and will sign off on a series of rights and consent statements, often referred to as “break the glass” rights. Upon sign off the updated information is pulled from the HIE to the local hospital EMR.

### Funding

- The Camden Coalition is run mostly on grants, of which the most notable came from Merck

#### The following hospitals contribute clinical data to the Camden HIE:

- Cooper University Hospital
- Our Lady of Lourdes- Camden
- Our Lady of Lourdes- Burlington
- Virtua Health System- Camden
- Virtua Health System- Marlton, Voorhees (ADT feed only)
- Kennedy Health System- Stratford
- Kennedy Health System- Cherry Hill
- Kennedy Health System- Washington Township

#### Additional local organizations contributing data:

- Labcorp (outpatient lab data)
- Bioreference (outpatient lab data)
- Quest Diagnostics (outpatient lab data)
- South New Jersey Perinatal Cooperative (perinatal risk assessments)

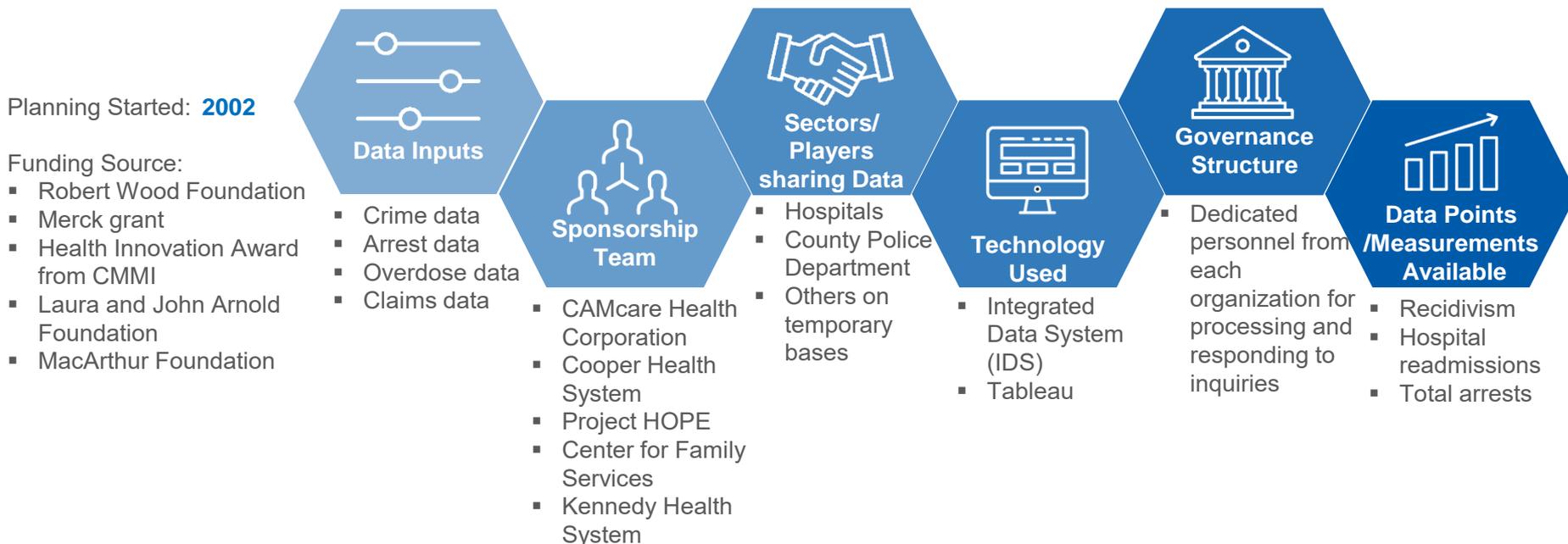
The Camden Coalition HIE is connected to two regional HIEs: the **Tren**

Sources: Camdenhealth.org, Data Sharing Agreement Between the Camden City School District and the Camden Coalition of Healthcare Providers, Memorandum of Understanding By and Between the Count of Camden and the Camden Coalition of Health Care Providers, and healthlaw.org

# CAMDEN, NEW JERSEY

## CAMDEN ARISE

Camden built an integrated data system (IDS) linking administrative data from healthcare, criminal justice, and other social services systems to allow research into overlapping issues in the delivery of healthcare and criminal justice services. Camden’s hospitals and county police, who are program anchors, work with other community stakeholders on a contract basis to augment data quality and quantity.



### Programs and Benefits Enabled:

- Allowed for “Hotspotting”: a tool within criminal justice including maps that are by historical record and leveraged to predict future activity
- Hospitals’ 7-Day Pledge to hospitalized individuals to meet with their primary care provider within a week of discharge

### Key Differentiators:

- Detailed data sharing agreements to standardize onboarding additional contributors, aside from the hospitals and county police
- Extensive grant funding, most notably from Laura and John Arnold Foundation

### Rationale for Selecting Comparable

- The purpose of conveying information about this comparable model is to illustrate how one community is utilizing a data warehouse to integrate and report on hospital and jail data.

### Purpose and Origins

- Camden Coalition was founded in 2002 and launched ARISE in 2015 for the purpose of driving better decisions about resource allocation and addressing the root causes of recurring public problems.

### Methodologies and Tools

- The Camden ARISE project is planned in multiple phases. The first integrates data from the Camden County Police Department with information from regional hospitals to shed light on overlapping issues in healthcare and public safety. While the strategic partnership is mostly between healthcare organizations and justice system organizations, the integrated data system (IDS) does include other institutions such as school systems for temporary data links. However, these are not permanent partners.
- IDS is housed on one hospital grade server. It collects crime data (13 discrete points), arrest data (16 points), overdose data (12 points), and computer-aided dispatch data (12 points).
- Metrics reported include hospital readmissions, arrests, recidivism, and others. Analysis of the combined data will indicate strategic points of intervention that may reduce hospital readmissions, arrests, and recidivism further.

### Funding

- Funding for the coalition came from: a Robert Wood Johnson foundation grant in 2007, a Merck grant in 2009, \$6 million Health Innovation award from CMMI, \$8.7 million in grants in 2016, and a \$15 million strategic partnership with UnitedHealth announced. Funding for the ARISE program is from The Laura and John Arnold Foundation.

Sources include: Camdenhealth.org , Data Sharing Agreement Between the Camden City School District and the Camden Coalition of Healthcare Providers, Memorandum of Understanding By and Between the Count of Camden and the Camden Coalition of Health Care Providers, and healthlaw.org

### Key Observations Enabling the Solution

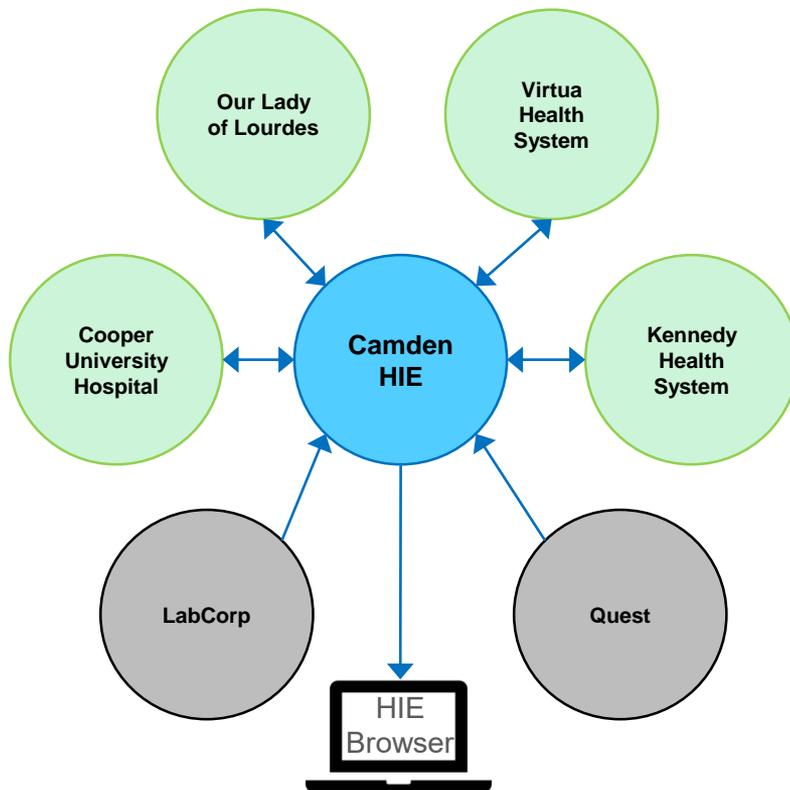
- The coalition has had strong leadership and vision from Dr. Jeffrey Brenner. The Lake County Mental Health Coalition is comprised of passionate leaders that can assume a similar role as Dr. Jeffrey Brenner to champion this change by creating a larger network and meeting with influential individuals across the Lake County behavioral health community.
- The data sharing initiative integrates data from cross-sectors - healthcare, criminal justice, and other social services systems. This is similar to the Lake County behavioral health community's desire to create a model that comprises organizations from each sector.
- The Camden Coalition is very fortunate to have both a HIE as well as a data warehouse to afford the community sophisticated care coordination approaches and data reporting capabilities. HIEs are expensive and establishing an HIE, as evidenced by the effort to establish a statewide HIE in Illinois, is difficult and costly. This is not an easy way to start data sharing and in an effort to make a positive difference within the community in short order and make effective investments for change, the Lake County behavioral health community should consider HIEs as longer term solution.
- The costs to implement the Camden solutions were high and the Camden coalition was able to obtain significant amounts of private and public funding to support their efforts. The Lake County behavioral health community will need to research public and private funding options as funding can impact the degree to which the Lake County behavioral health community can pursue advanced solutions such as an HIE.

# CAMDEN COALITION OF HEALTHCARE PROVIDERS

The Camden Coalition of Healthcare Providers utilizes two different models for data sharing among its partners:

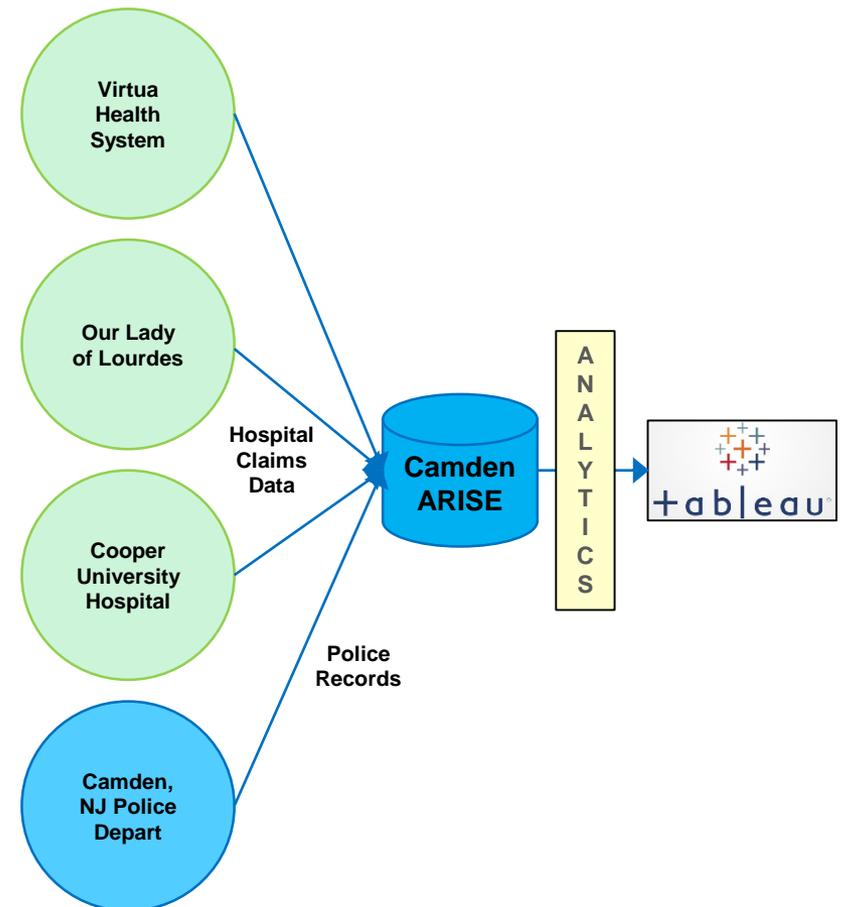
## Camden HIE

### • Data Sharing Model

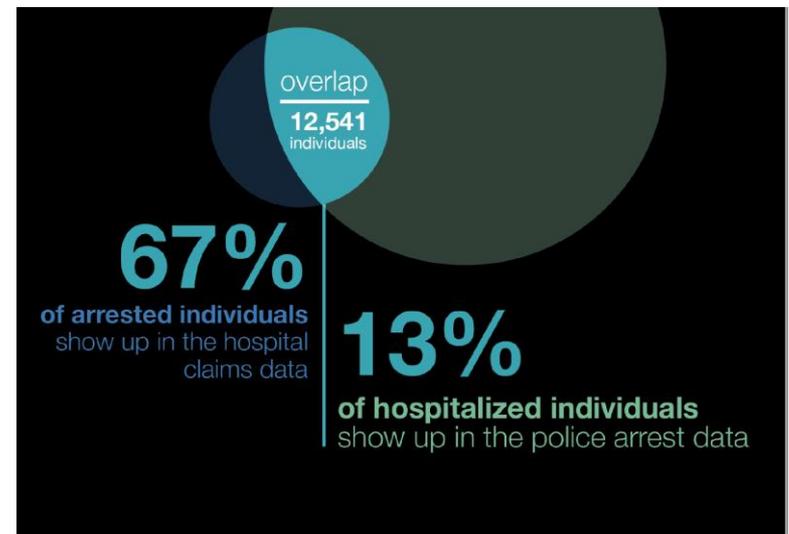
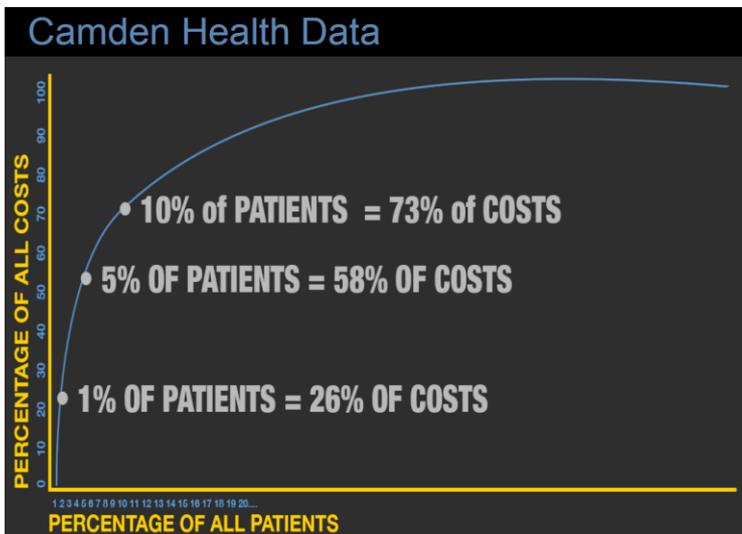
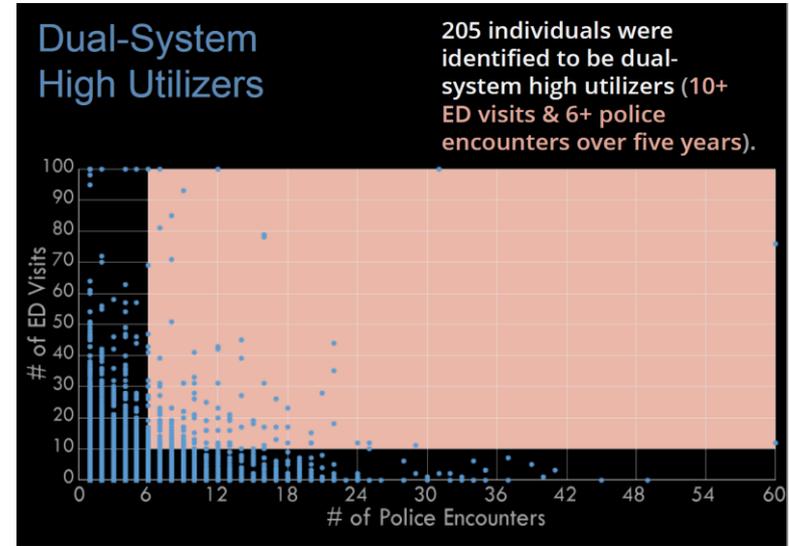
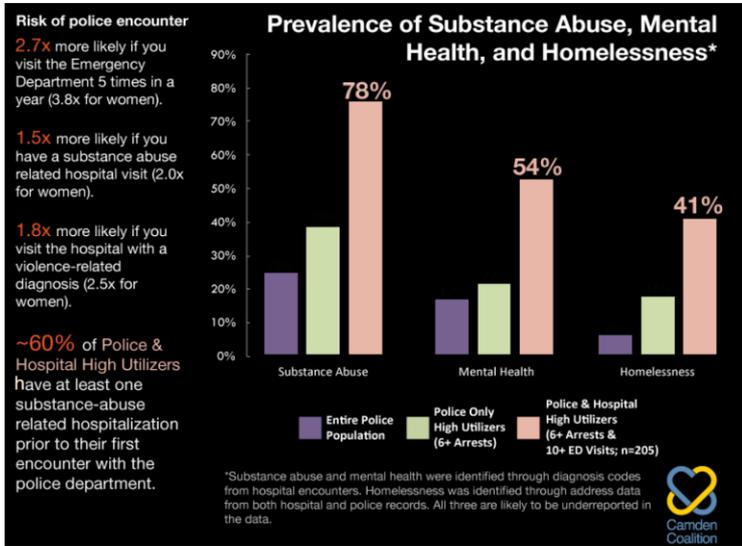


## Camden ARISE

### • Data Integration Model



# DATA AVAILABLE FROM CAMDEN'S ARISE DATA WAREHOUSE



## 3.1.4 THEORETICAL MODELS

### OPTIONAL DATA SHARING MODELS FOR LAKE COUNTY

#### Introduction to Optional Data Sharing Models

Following the information provided in the Current Data Sharing Assessment and the research of comparable communities, North Highland developed optional data sharing models for the Lake County behavioral health community to be evaluated to determine the best fit for the Lake County behavioral health community.

Several options for data sharing were analyzed and consistencies across the options were extracted and categorized into the following four types of data sharing models: silo, point-to-point, central repository, and hybrid. An overview of these data sharing models is on the following page.

These models provide optional frameworks to categorize and compartmentalize a high volume of new data for the Coalition and stakeholders. These frameworks also established a common language to digest and discuss the complex information presented in the *3.1.3 Comparable Data Sharing Models from Other Communities* section so that members could begin to understand options, consider what might work best for the Lake County behavioral health community, and align to a framework to meet its objective.

#### Facilitation

Following facilitated discussions to identify and prioritize key decisions on data sharing models, the Coalition and community stakeholders evaluated the pros, cons, strengths, weakness, and opportunities of the model options for the Lake County behavioral health community. Coalition members discussed both the short and long-term plan for developing models and members explored what the evolution of these models could look like, using examples from the comparable communities and sharing what they believed to be the most feasible.

A description of the facilitated discussion on optional models is located in *3.3 Facilitated Discussions* and the model that North Highland recommends is included in section *5.1 Recommendations*.

# THEORETICAL MODELS FOR EXPLORATION



	<b>SILOS</b>	<b>POINT TO POINT</b>	<b>CENTRAL REPOSITORY</b>	<b>HYBRID</b>
<b>Definition</b>	Limited or no communication externally of data	Entities send information to some other single entity in discrete transactions	All participating orgs contribute to a central data hub and can pull appropriate information as needed	Provides various combinations of point-to-point and central repository models.
<b>Pros</b>	<ul style="list-style-type: none"> <li>Requires no shared governance structure</li> <li>No reliance on other organizations</li> </ul>	<ul style="list-style-type: none"> <li>High degree of control of what information is seen and by whom</li> <li>Low technology cost</li> </ul>	<ul style="list-style-type: none"> <li>Allows for more sophisticated, cross-sector data points</li> <li>Governance is established at beginning</li> </ul>	<ul style="list-style-type: none"> <li>Allows for more sophisticated, cross-sector data points</li> <li>Leverages existing infrastructure and technology in place</li> <li>Model allows flexibility for growth and evolution to future state</li> </ul>
<b>Cons</b>	<ul style="list-style-type: none"> <li>Long-term economic loss for community</li> <li>Is not a patient centered approach</li> </ul>	<ul style="list-style-type: none"> <li>Operation dependencies for submission and receipt processing</li> <li>Significant limitations for system-wide data</li> </ul>	<ul style="list-style-type: none"> <li>Most expensive to execute, generally</li> <li>Requires most buy-in from participants</li> </ul>	<ul style="list-style-type: none"> <li>Challenges coordinating different technology</li> <li>Might require on-going data governance</li> </ul>
<b>Potential Methodologies</b>	<ul style="list-style-type: none"> <li>Methodology only dependent on organizations needs</li> </ul>	<ul style="list-style-type: none"> <li>Phone calls</li> <li>Emails</li> <li>Faxes</li> <li>Direct messages</li> <li>Paper</li> </ul>	<ul style="list-style-type: none"> <li>Data warehouse</li> <li>Health Information Exchange (HIE)</li> </ul>	<ul style="list-style-type: none"> <li>Combination / mixture of other methodologies</li> </ul>

**Each model has its benefits and challenges and can be blended or customized to meet the needs of the Lake County behavioral health community.**

## OPTIONAL MODELS FOR LAKE COUNTY

Below is a description of how each of these models could relate to the Coalition and communities members' prioritized questions and an introduction to the characteristics of each model that informed its development and why it was presented as an optional model for the Lake County behavioral health community. These are organized in ascending order by the complexity of the model.

**Option 1 – Silo:** This model illustrates the framework that some Lake County organizations follow today. Silos are a compliant model as it does not involve regular, programmatic data sharing and the model's internal focus may enable an organization to be more nimble with their own data. However, the model does not promote a care coordination network through data sharing, which is a key priority of the Coalition and community. Nor does it enable the Lake County behavioral health community to recognize answers to systemic questions.

**Options 2 & 3 – Point to Point model:** Different entities expressed interest in specific data from other organizations. While they may be receiving some of the data points listed, they may want higher quality, more timely access to the information, or systemic sharing processes in place to receive the data more regularly.

**Option 4 – The Central Repository Model for Aggregated Data:** During interviews and coalition meetings, individuals expressed a frustration with care coordination and a desire to know what services available, in real-time, at a specific location. This question and other service capacity questions can be answered through aggregated data. While the data is often aggregated by the system if it houses raw underlying data, sharing aggregated data to a central repository would be compliant with the three legal data sharing barriers cited during interviews and allow greater insight.

**Option 5 – Central Repository Participant-Level Data:** Identifiable information must be shared to answer the Coalition and behavioral health community's prioritized question of "who is seeking access to services" and arrive at the total number of unique individuals seeking care. Having PII to answer this question, then leads to the answer to several related questions such as "who are the high utilizers" and the recidivism rates. This model was designed to show the power of participant-level data as it relates to the ability to answer questions.

**Option 6 – The Hybrid Model (Longer-Term Vision):** Most of the established programs in comparable communities have evolved into a hybrid model as the details behind sharing data surface and as the programs themselves adapt to address ever-changing issues. This model was designed to show a long-term vision for the Coalition and behavioral health community and how the program may evolve from data collection to a hybrid solution. It is important to note that this is an complex model that makes a number of assumptions.

The next pages describe each model option in detail.

# DATA SHARING – SILOS

## Description:

- Organizations stand and function alone, with minimal to no interaction with others.
- Each organization collects, stores, and uses its own data which it can use to interact with the public.
- Any aggregation of data and reporting is self-contained to each organization.

## Data Sharing:

- Minimal to no data sharing with other organizations

## Technology Used:

- Applications (off the shelf), databases, and reporting tools that each organization decides to buy or build
- There is no leveraging of technologies between organizations

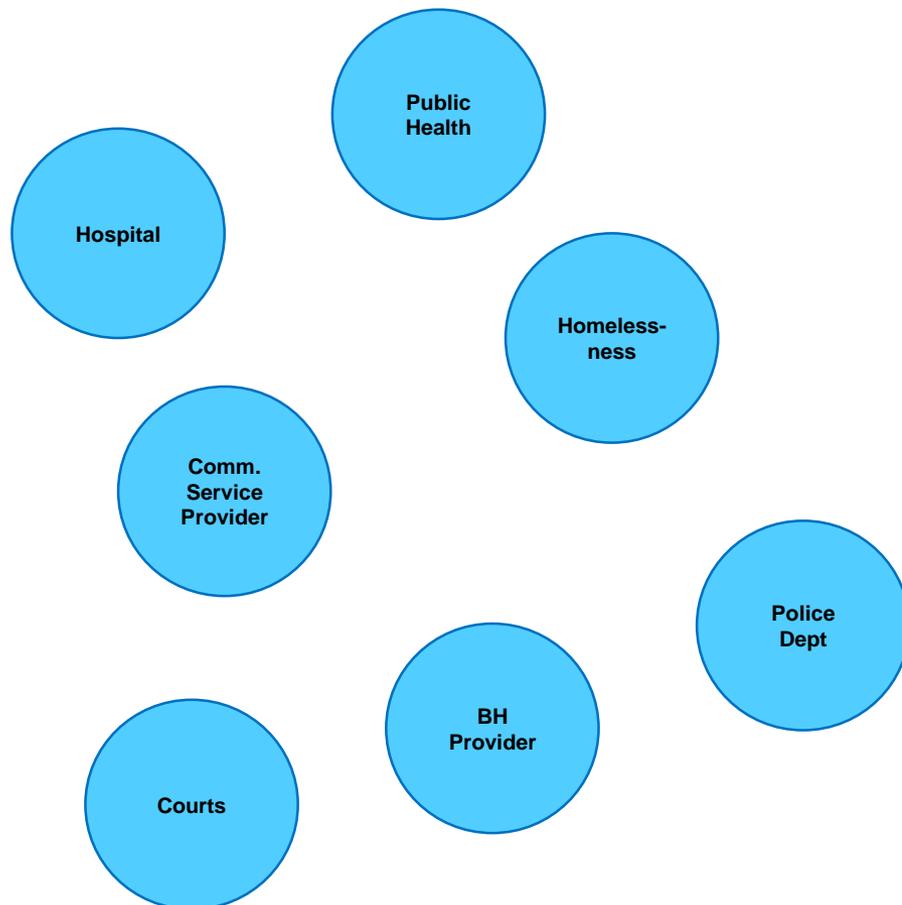
## Data Governance:

- Governance is left to each organization to define and use data as they see fit

## Resources:

- Each organization must operationally and financially maintain and support the technology used

## DATA SHARING OPTION 1 – SILOS



### Strengths

- Organization data is aggregated at a specific time or through internal dashboards, which may be real-time
- Organization specific data is available for grant information and data collection
- Organization manages and controls access to PII according to its own standards and policies
- Internal focus allows organizations improve data collection and quality per its own discretion and chosen strategic direction

### Weaknesses:

- Data sharing is minimal, nonexistent, or only done on a situational basis as need be
- Care coordination across organizations is more difficult without information on complementary service availability
- Insights across the entire behavioral health community do not exist unless there is a single service provider for the whole county (i.e. jail)

Lake County Examples (not inclusive of all entities)

# DATA SHARING – POINT TO POINT

## Description:

- Point to point data sharing involves two organizations who agree to share data with one another, usually a specific data set that is of value to one or both organizations.
- A given organization can have multiple point to point data sharing agreements in place, often leading to repeated/redundant processes duplicated for each organization that data is shared with.

## Data Sharing:

- Data is shared using varied electronic means, as agreed between the two organizations.
- Data standardization definitions are determined per relationship as well as the control framework for the technology systems involved (i.e. name formats between an EMR and Excel program)

## Technology Used:

- Electronic communication tools, such as email, secure FTP (SFTP), Direct Messaging
- If an organization has more than one agreement, additional technologies or data transformation systems may need to be put into place
- Point to point data sharing can be done with relatively low-level technology (e.g. spreadsheets), which enables more individuals to take part, but results in greater onus on organizations looking to consolidate received data.

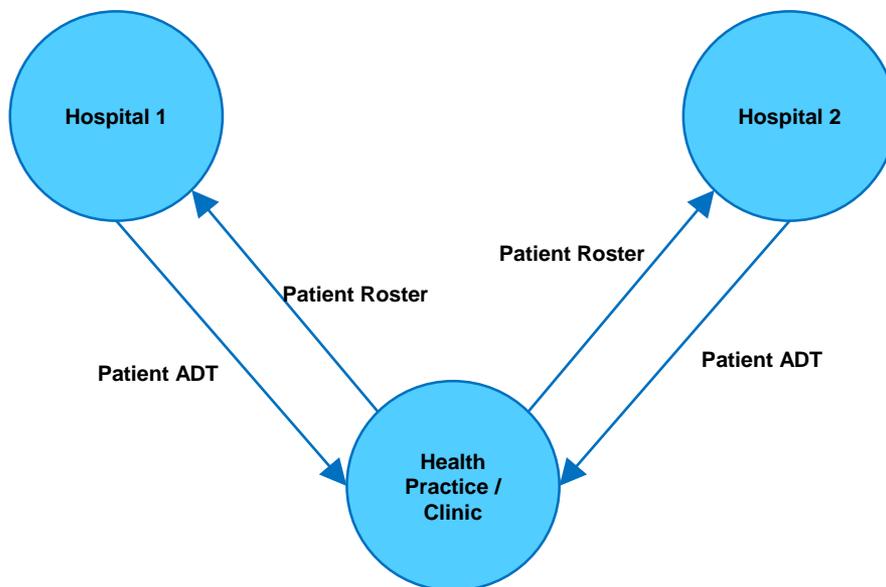
## Data Governance:

- Governance is defined by the two organizations involved in terms of content and format.
- A typical structure requires data extraction to be owned by a team or individual, and with data transfer technologies defined per system involved. Depending on the number of relationships, this can be costly from an operational and financial standpoint.

## Resources:

- It is relatively quick and easy to set up a point to point data sharing agreement and process; however, it can become unwieldy and inefficient as the number of point to point agreements grows.

## DATA SHARING OPTION 2 – POINT TO POINT



The Health Practice/ Clinic will inform each hospital, separately, of its patient roster. The hospitals will take that data and notify the health practice/ clinic when a patient comes to the ED or has an inpatient stay.

Lake County Examples (not inclusive of all entities)

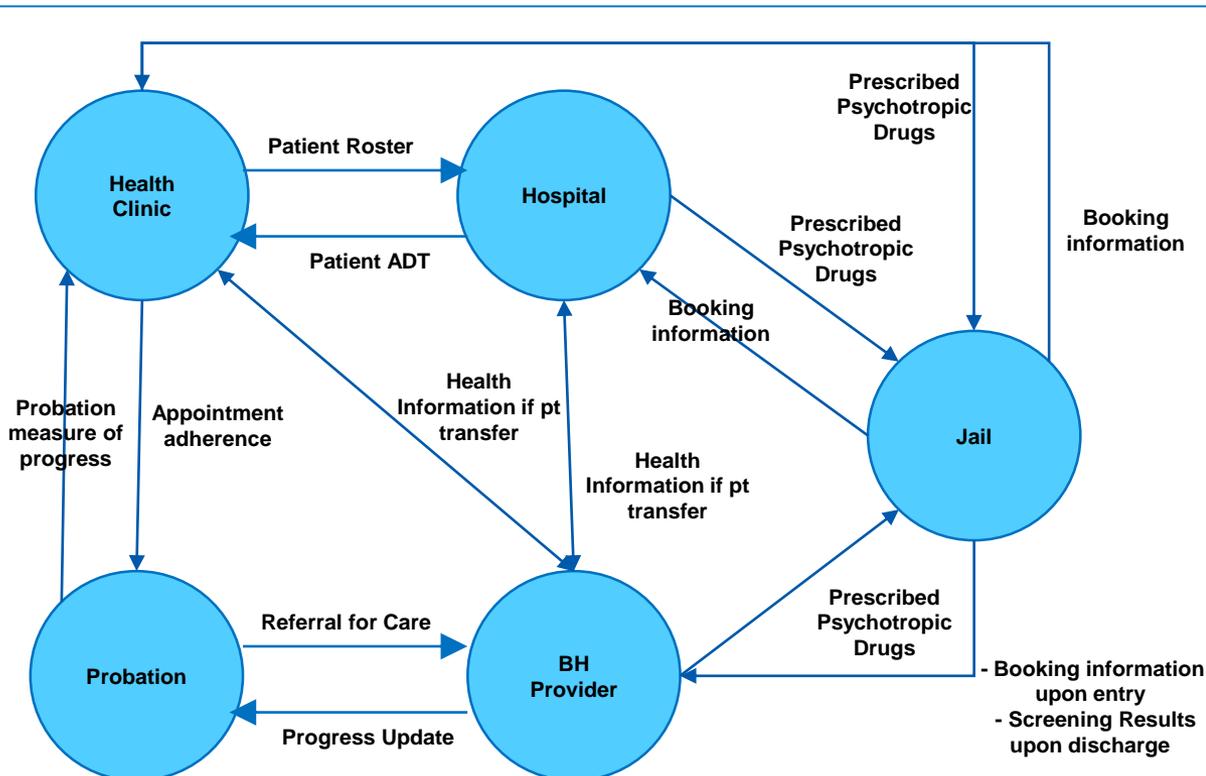
### Strengths

- Care coordination is improved amongst entities with agreements
- Increased insight into patient story across organizations, which can be particularly powerful with the following two data points
  - Number of ED Visits for the clinic's patients
  - Number of Inpatient Stays for the clinic's patients

### Weaknesses:

- Requires separate agreement per entity relationship
- The entity has to have a record of which outside clinic each patient is associated with within their EMR or a scanning program that aligns PHI and PII through an automated process.
- This model does not lend itself to aggregate metrics across the Lake County behavioral health community.
- In order to aggregate metrics across the entire county, a point to point connection would need to be set up with all similar service providers.

## DATA SHARING OPTION 3 – POINT TO POINT



When an individual is brought to the jail and booking is complete, that information is sent to a local hospital, health clinic, and behavioral health provider which is made possible per three separate point to point agreements between the jail and each of the three service providers. In return, the health facilities can send data as appropriate to the jail about the individual. Thus, the jail is then able to more quickly assess and provide needed services. Healthcare providers also have agreements with probation to share appointment adherence information and in return receive information from probation on the individual's progress on the social determinants of health.

Lake County Examples (not inclusive of all entities)

### Strengths

- Know the total inmates with behavioral health within 72 hours across the system (because there is only one jail in the system.)
- Hospital follow up program for recently released inmates could be result of more information
- Improved cross-system services tracking possible for primary providers
- Known healthcare visits across multiple facilities (but not all)
- Key indicators of progress made available to probation for improved tracking
- Does not require robust technology to get started

### Weaknesses

- Requires unique agreement terms per relationship and individuals to manage the data sharing at each participating organization
- For services offered through multiple providers, an organization would need to contract with all similar service providers to understand the whole picture
- Partnerships with a set of providers could exclude complementary services that would be beneficial to the individual with behavioral health needs
- Demands operational resources to maintain unique participant lists, data fields, and sharing processes per agreement

## DATA SHARING OPTION – CENTRAL DATA REPOSITORY

### Description:

- A central data repository or warehouse is a large store of data accumulated from a wide range of organizations and data sources. It is used to aggregate and process large amounts of data, execute complex queries, and report out information for decision making.
- Data warehouses (DW) normalized data across all organizations providing the data, therefore the data will be cleansed and consistent, providing “single version of truth”. The quality of data/report output is only as good as the data provided from those organizations contributing to the repository.

### Data Sharing:

- **Data is shared in one direction only:** All organizations, who want to contribute/share data, will create data extract files (pre-defined and agreed upon format and content) and send them to a central repository
- The central repository will gather all data, check for alignment with data quality rules (with corrections made as necessary), combine and normalize the data, and store it in a central data repository or warehouse.
- Data is not limited to healthcare data

### Technology Used:

- The organization who maintains the data repository must set up a database, along with ETL (extract, transform, and load) tools/processes to receive data and load it into the repository.
- The organizations providing the data must extract data from their internal systems and package the data into files in formats as agreed upon by the participants.

### Data Governance:

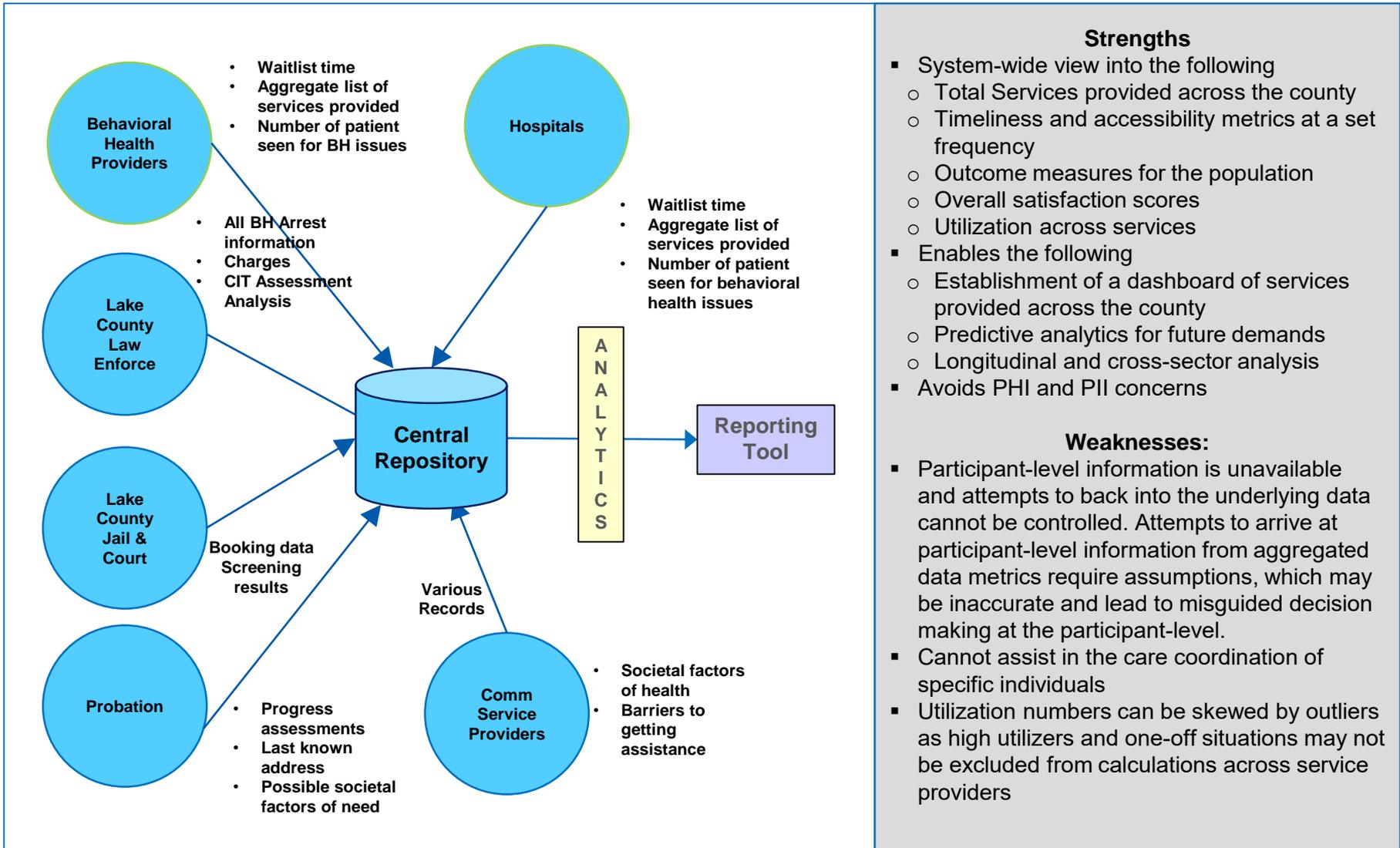
- Data governance is key to a central data repository. All parties must agree to the quality and format of the raw data being provided as well as rules for consolidating the data, executing calculations, and report output. This requires significant coordination.

### Resources:

- The cost can be high to implement a central repository. Each data source may also require some technology updates to participate, such as an automated file transfer program.

# DATA SHARING OPTION 4 – CENTRAL DATA REPOSITORY

## AGGREGATED DATA METRICS



### Strengths

- System-wide view into the following
  - Total Services provided across the county
  - Timeliness and accessibility metrics at a set frequency
  - Outcome measures for the population
  - Overall satisfaction scores
  - Utilization across services
- Enables the following
  - Establishment of a dashboard of services provided across the county
  - Predictive analytics for future demands
  - Longitudinal and cross-sector analysis
- Avoids PHI and PII concerns

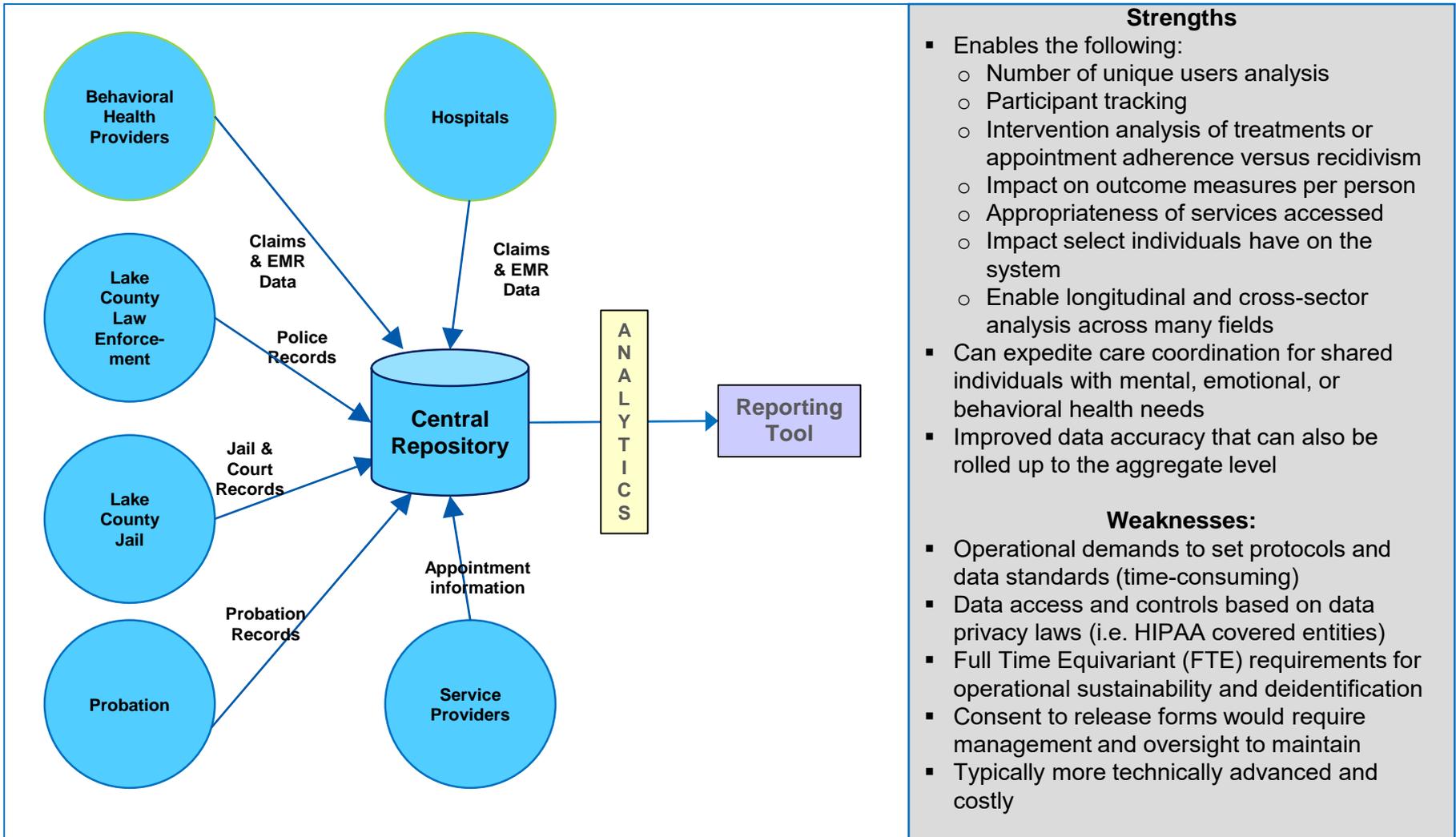
### Weaknesses:

- Participant-level information is unavailable and attempts to back into the underlying data cannot be controlled. Attempts to arrive at participant-level information from aggregated data metrics require assumptions, which may be inaccurate and lead to misguided decision making at the participant-level.
- Cannot assist in the care coordination of specific individuals
- Utilization numbers can be skewed by outliers as high utilizers and one-off situations may not be excluded from calculations across service providers

Lake County Examples (not inclusive of all entities)

# DATA SHARING OPTION 5 – CENTRAL REPOSITORY

## PARTICIPANT-LEVEL DATA



### Strengths

- Enables the following:
  - Number of unique users analysis
  - Participant tracking
  - Intervention analysis of treatments or appointment adherence versus recidivism
  - Impact on outcome measures per person
  - Appropriateness of services accessed
  - Impact select individuals have on the system
  - Enable longitudinal and cross-sector analysis across many fields
- Can expedite care coordination for shared individuals with mental, emotional, or behavioral health needs
- Improved data accuracy that can also be rolled up to the aggregate level

### Weaknesses:

- Operational demands to set protocols and data standards (time-consuming)
- Data access and controls based on data privacy laws (i.e. HIPAA covered entities)
- Full Time Equivariant (FTE) requirements for operational sustainability and deidentification
- Consent to release forms would require management and oversight to maintain
- Typically more technically advanced and costly

Lake County Examples (not inclusive of all entities)

## COMPARISON OF ESB, HIE, & DW

Several systems can enable data sharing and a central repository model, and understanding the characteristics of each can help the Coalition determine the best fit for the Lake County behavioral health community.

### Enterprise Service Bus (ESB)



- Is a communication system between mutually interacting software applications in a service-oriented architecture (SOA).
- Is NOT a database – while an ESB communicates information between applications and their respective databases, the ESB itself is not a database.
- Typically used in non-healthcare settings to exchange non-healthcare data
- Data is routed, between various applications, in packet messages (XML) that are transmitted and received via the ESB
- Used to exchange data between older legacy systems with current systems
- Code must be written to allow an application to be used on an ESB. In addition, the application's database must be accessible to write the code.
- Work best within the “4 walls” of an entity, as it is not advisable to send data via the open internet due to data security & privacy concerns.

### Data Warehouse (DW):



- Is large store of data accumulated from a wide range of organizations and sources
- Used to aggregate and process large amounts of data, execute complex queries, and report out information for decision making
- Is not directional. Data flows uni-directionally into the data warehouse on a pre-determined regular basis.
- Is a large database, with the tools and processes to ingest data from many different sources.
- Data is exchanged by the use of flat files in pre-arranged formats and transmitted via secured methods (e.g., SFTP)
- Data warehouses normalized data across all organizations providing the data, therefore the data will be cleansed and consistent, providing a “single version of the truth.” Quality of data/report output is only as good as the data provided and often failed files will prompt senders to update formatting or errors.
- Once data has been collected and normalized, analytics are oftentimes applied, and reports are generated.

### Health Information Exchange:

- Provides the capability to electronically move healthcare information, and only healthcare information, among disparate healthcare information systems, and maintain the meaning of the information being exchanged.
- Provides both the communication system and central database
- Allow for data exchange/communication to be bi-directional, on a real-time basis – but only between healthcare partners who have healthcare information systems
- Allows the exchange of healthcare data via HL7, C-CDA, or FHIR: ADTs, vitals, labs, meds, image texts, physician notes
- Does not allow for the exchange nor storage of non-healthcare/medical record data (e.g., jail bookings, 911 call data, etc.)
- Requires a significant investment to build – typically sponsored by a very large healthcare institution or state government
- HIE's currently can connect and exchange data with other HIEs but NOT with other types of networks. Interoperability with other non-healthcare networks is an area of significant research.

## DATA SHARING OPTION – CENTRAL DATA REPOSITORY

### COMPARISON OF AGGREGATED DATA VS. PARTICIPANT – LEVEL DATA

Aligning the value that different types of data, such as aggregated data metrics or participant-level data, can provide with the needs of the Lake County behavioral health community is critical to determining the type of data that will need to be collected and shared. While participant data can roll up into aggregated data and provide for robust analysis as outlined in the Data Sharing Hierarchy (see 2.2 *Data Sharing Project* purpose), the challenges to accessing and managing the information must be considered when evaluating the model that will work for the future data sharing within Lake County.

#### Aggregated data

- Focused on collecting summarized data/reports from entities, avoids the need to provide personally identifiable information
- Smaller volume of data
- Less time to establish
- Can provide insight into operations across organizations (i.e. average wait times for beds, appointments, etc.) within the county
- Can assess overall trends for the services accessed
- Aggregated data / reports would make it more difficult to match up data within a sector or with other organizations since the aggregation methods may be different between the different organizations
- Individual metrics unavailable to measure outcome or progress
- Limited analysis capabilities of the data when compared to patient-level information
- Cannot assist in the care coordination of specific individuals

#### Participant-level data

- Improved data accuracy, that can also be rolled up to the aggregate level
- Enable longitudinal and cross-sector analysis across many fields
- Can expedite care coordination for shared ‘clients’
- Can track individual outcomes and address intervention opportunities
- Data could be sent at the participant-level and de-identified
- Release of information required due to security and privacy laws
- Focused on collecting data at the individual level from all entities, which necessitates passing PII (personally identifiable information) data
- Requires sufficient information/data to match individuals’ data across different sectors and multiple data source entities
- Larger volumes of data
- Longer time investment to build
- Requires business rules/logic and processing to ensure the correct matching of individuals’ data
- Requires a significantly higher cost to implement

## DATA SHARING OPTION – HYBRID MODEL

### EXTENDED LONG TERM VIEW: HYBRID MODEL

As evidenced through research of comparable communities, most programs evolve into a hybrid model which blends central repository and point to point models described above. Arriving at a hybrid model takes a long time given the volume of relationships and investments required to build an elaborate architecture for data sharing. This model was created to provide a vision of a potential long-term framework for data sharing that can result from the beginning with point to point and central repository models.

The data sharing, technology used, data governance and resources are highly variable depending on the point to point and central repository relationships established as the model evolves.

#### Hybrid Model Description:

The data warehouse will serve as the central repository for all data shared by the coalition. Many business and technical details would need to be defined and worked out, as it is uncommon, today, to pull data from a HIE and an enterprise service bus into a data warehouse. Research continues to advance interoperability and the capabilities of these technologies, but currently, these connections are not feasible.

The Health Information Exchange (HIE) will connect all healthcare service providers (hospitals, behavioral health providers & clinics, Health Center PC FQHCs, Medicaid Managed Care Plans, etc.) to share, bi-directionally, individuals' electronic medical records on a real-time basis. Additionally, the HIE would communicate with other HIEs to further expand the network of individual electronic medical records.

This hybrid model introduces a crisis system, including a crisis call command center, mobile crisis teams, and walk-in crisis facility, to store information that can also be included in the HIE. The process includes calls coming into the crisis call center (from ED's, 911, and law enforcement) with requests to assist with individuals exhibiting behavioral health issues. The crisis call center will coordinate with mobile teams to dispatch professionals to assess and direct the individual to the best location of care, which may be the walk-in crisis center. These interactions provide data on the service needs of the behavioral health community.

The Justice Enterprise Service Bus will continue to allow the many different, related justice entities to exchange pertinent pieces of information between various applications.

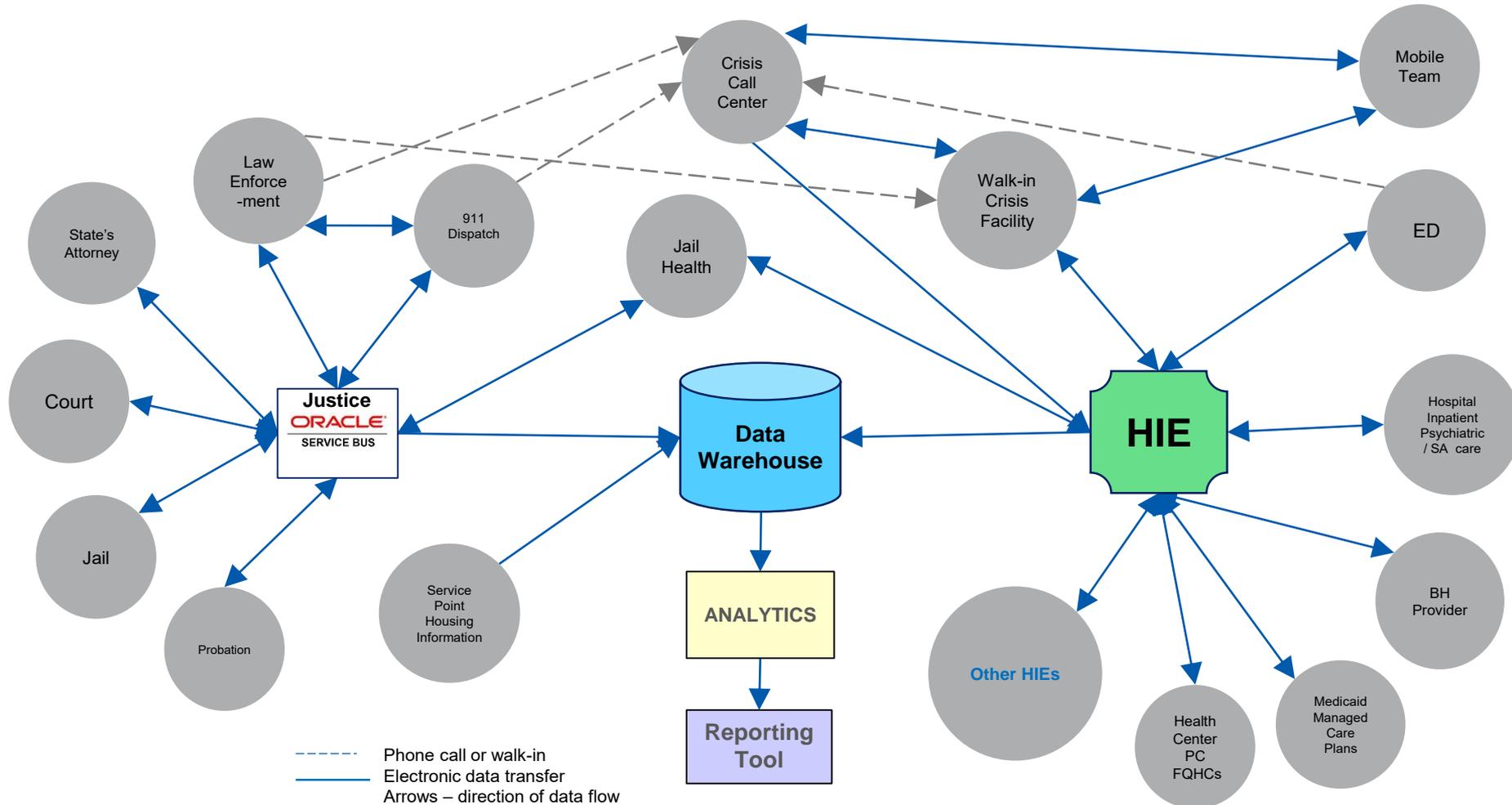
Service Point, or another similar central repository, would continue to house and share homelessness, housing, and referral information across sectors.

Finally, analytics and reporting tools would sit on top of the data warehouse so that analytics can be applied to that data, and reports can be generated and distributed for decision making.

# DATA SHARING OPTION 6 – HYBRID MODEL

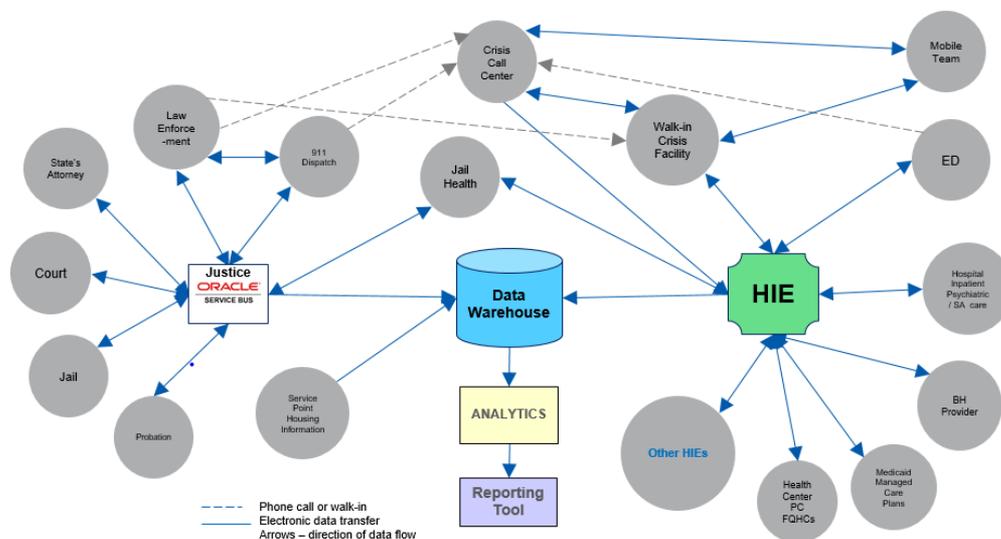
## EXTENDED LONG TERM VIEW: HYBRID MODEL

The picture below is a hybrid model involving the types of organizations within Lake County. The eventual model that will work for Lake County will be the product of many decisions that will need to take into consideration a large number of factors such as needs, feasibility, costs, benefits, size of populations etc. It is important to consider what is realistic and feasible when evaluating the additional data sharing relationships to establish as the model evolves.



# DATA SHARING OPTION – HYBRID MODEL

## EXTENDED LONG TERM VIEW: HYBRID MODEL



117

### Strengths

- Cross-sector electronic communication enables faster data analysis
- Hot spotting and information sharing to help sector organizations (high mental health need area coupled with higher demands on justice system)
- More robust care coordination across-sectors
- County-wide outcome measurements including trend data and more robust ability to identify determinants
- Data results from the model can help to answer detailed outcome questions

### Weaknesses:

- Change requests can have unforeseen downstream effects depending on the evolution of the program.
- Increased complexity of the model demands additional and dedicated data governance and management
- Takes a very long time to establish
- The model is dependent on factors that may be out of the Lake County behavioral health communities direct control. For instance, HIEs are costly to implement and if implemented will likely serve a purpose larger than a single county. Many states have attempted to implement a HIE but find they compete with private information exchanges, such as those established by EMR products. If a HIE is implemented, it may be by the state will also likely serve more than just the behavioral health population. If this is the case, the Lake County's behavioral health community has less influence on the design and processes of the HIE and will need to adapt the behavioral health data sharing model to the decisions and the design of the HIE at the state level.

# THEORETICAL MODEL OBSERVATIONS

Evaluating the pros and cons of the theoretical data sharing models specifically as it relates to the ability to make the desired decisions can identify the type of model needed within Lake County. The hybrid model was excluded from this analysis as it is a composite of the below relationships, a longer-term vision, and currently not feasible without preceding steps.

## Point to Point:

### Pros

- Easier to set up as there are fewer parties involved and agreements can cater more to organizational capabilities and preferences.
- More control over data shared as less legal entities are involved
- Greater flexibility with change management- needed practices to share data are confined to the parties involved the change management plan needs
- Lower barrier to release of information being signed- fewer organizations sharing data and patient willingness may be greater with the less distribution

### Cons

- Limited to the data available and exchanged between the two entities, which may likely be within the same service provider category (i.e. hospitals) and so information from other organizations is not shared.
- System-level insights are only achieved if one organization is working with every other organization which is operationally difficult
- High operational demands relative to output (requires a data analyst to submit data and process received data, whereas automation with a central repository alleviates this burden)

## Central Repository:

### Pros

- Allows data integration and normalization of data from different organizations as the data cleaning process is owned by the central repository processes and operators
- Standardizes data/metrics across organizations
- Enhanced data consistency and quality
- Data retrieval is fast as it is typically automated and not dependent on manual processes
- Allows for analytics and advanced processing once built as the availability of more data allows for a higher volume of trend and relationship analysis

### Cons

- Long time to set up
- Front loaded data governance demands
- Can be costly depending on the medium and business requirements of the program.
- On-going maintenance costs (changing requirements & maintaining infrastructure as it grows)

# THEORETICAL MODEL OBSERVATIONS

Two aspects pertinent to understanding the best model for Lake County include 1) the type data needed to answer the questions prioritized by the Coalition and Community members, namely who is seeking services and what services do they need, and 2) the functionality required of a data sharing program, namely because the data will be used to answer questions, measure trends over time, and make decisions.

## Identified Data vs Deidentified Data

Understanding the value of identified and de-identified data relative to the desired use of the data can determine the type of information to be collected.

### Identified Data

- Can help Lake County determine the unique number of users
- Can allow for identifying high utilizers (*Hot Spotting*), interventions, and personalized care plans
- Required for matching individuals' data across sectors (e.g., hospital data and jail data)

### Deidentified Data

- Can analyze trends across categories such as demographics
- To arrive at the unique number of users across a county, identified information would need to be submitted and then de-identified through an agreed-upon process.

## Data Storage and Data Sharing

Data warehouses have the functionality to store data and to share that data in many different ways. The desired functionality should be included in the design of the future data sharing model.

### Data Storage

- Data can be collected and stored from a wide range of related and unrelated data sources; this data can be organized into logical data domains
- Data can be stored from a wide range of time periods, allowing the ability to capture metrics over history and allowing longitudinal trend analysis
- Data can be stored in various levels of summary/ aggregation. It can also be stored at the most granular level, then allowing that data be aggregated to various reporting levels

### Data Can Be Shared by:

- Allowing a reporting tool to generate various reports to be emailed out or stored in a central location for access
- Allowing users to pull data/reports on-demand based upon their needs
- Building a web server where users can log in to pull existing reports or query the data warehouse
- Allowing advanced processes and technologies to transmit data electronically from the data warehouse to another application

## 3.1.5 DATA GOVERNANCE

Data Governance (DG) refers to the overall management of the availability, usability, integrity, and security of the data employed in an enterprise or coalition. A sound data governance program includes a governing body or council, a defined set of procedures, and a plan to execute those procedures. It is very difficult to get consistent, accurate, reliable data without Data Governance.

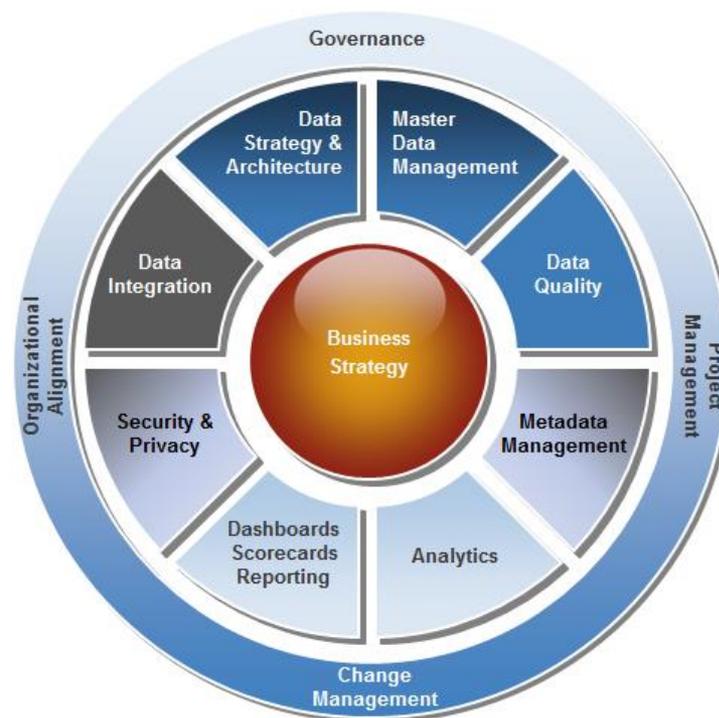
### Value of Data Governance

- Open communication across coalition entities, processes, and functions
- A common language & definitions around critical information, metrics, & data
- Clear ownership of information, metrics, and data sources
- Increase capability for ensuring data quality & integrity
- A clear understanding of compliance risks and mitigations

### Key Components

Data governance consists of various components that **align** information to the **business strategy** through **people, processes, and technology**. Some key components of data governance are below.

- Governance
- Operational Components
  - Master Data Management
  - Data Quality
  - Metadata Management
  - Analytics
  - Dashboards, Scorecards, and Reporting
  - Security and Privacy
  - Data Integration
  - Data Strategy and Architecture
- Project Execution Components
  - Project Management
  - Change Management
  - Organizational Alignment



## KEY COMPONENTS OF DATA GOVERNANCE DETAIL

Component	Purpose	Enables Coalition To:
<b>GOVERNANCE</b>	Aligns the coalition members with the overall coalition data sharing strategy and enables prioritization of initiatives as well as a plan for the introduction of processes that will continuously monitor and improve data quality.	<ul style="list-style-type: none"> <li>Establish policies, standards and guidelines for each of the key data management capabilities</li> <li>Identify stakeholders who are held accountable for decision-making and authority for data-related matters</li> <li>Identify who is “accountable” for what data and implement discipline to draw insights from data</li> </ul>
<b>MASTER DATA MANAGEMENT</b>	The implementation of repeatable sets of business rules as well as supporting data management and data distribution systems that define the value, content, and structure of specific data and data attributes.	<ul style="list-style-type: none"> <li>Define and standardize the data that is common and shared across entities and IT systems</li> <li>Improve confidence in data provided through reporting and business intelligence solutions</li> <li>Obtain insights from data across the coalition for better and faster decision making</li> <li>Increase business process execution speed and improve quality of outcomes</li> </ul>
<b>DATA QUALITY</b>	The processes and tools for verifying data within source systems and following standards so that business rules are in place to govern the usage and movement of data.	<ul style="list-style-type: none"> <li>Have trust in the information provided from the various entities’ operational and analytical systems.</li> <li>Ensure users will be confident in the decisions they make and the manner in which they utilize the data</li> <li>Free up analyst to spend more time on analyzing data vs. cleaning and “fact checking” the data</li> <li>Provide the bedrock component of a successful information management solution</li> </ul>
<b>DASHBOARDS, SCORECARDS, REPORTING</b>	The process of converting transaction or production information into useful knowledge via available reporting tools for real-time dashboard, snapshot (scorecard), and detailed data display (reporting).	<ul style="list-style-type: none"> <li>Provide actionable information to decision makers in user friendly format that fits the way they work</li> <li>Capture real-time status of business execution and performance across the coalition or within a specific area</li> </ul>
<b>SECURITY &amp; PRIVACY</b>	Addressing and maintaining organization security and data privacy standards, which are paramount to data management. In addition, assessing the current tools used to access and make reports and information available to users, which is critical to remaining compliant with both internal and external data standards.	<ul style="list-style-type: none"> <li>Set the policy for how data should be classified and managed in a safe and secure manner</li> <li>Maintain compliance with federal and state regulations for specific types of data such as Personal Identifiable Information (PII) and Personal Health Information (PHI)</li> <li>Ensure that only the appropriate people and systems have access to marked data</li> <li>Integrate data security into your Cyber Security strategy</li> </ul>

## DATA GOVERNANCE APPROACH

The approach to data governance requires that people, processes and technology considerations be addressed:

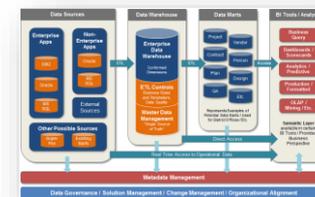
**People:** A team of individuals is needed to manage formal data governance structure to make key decisions related to data and information.



**Process:** Training Lake County on the data governance structure and implementing standard processes & routines for the governance of data.



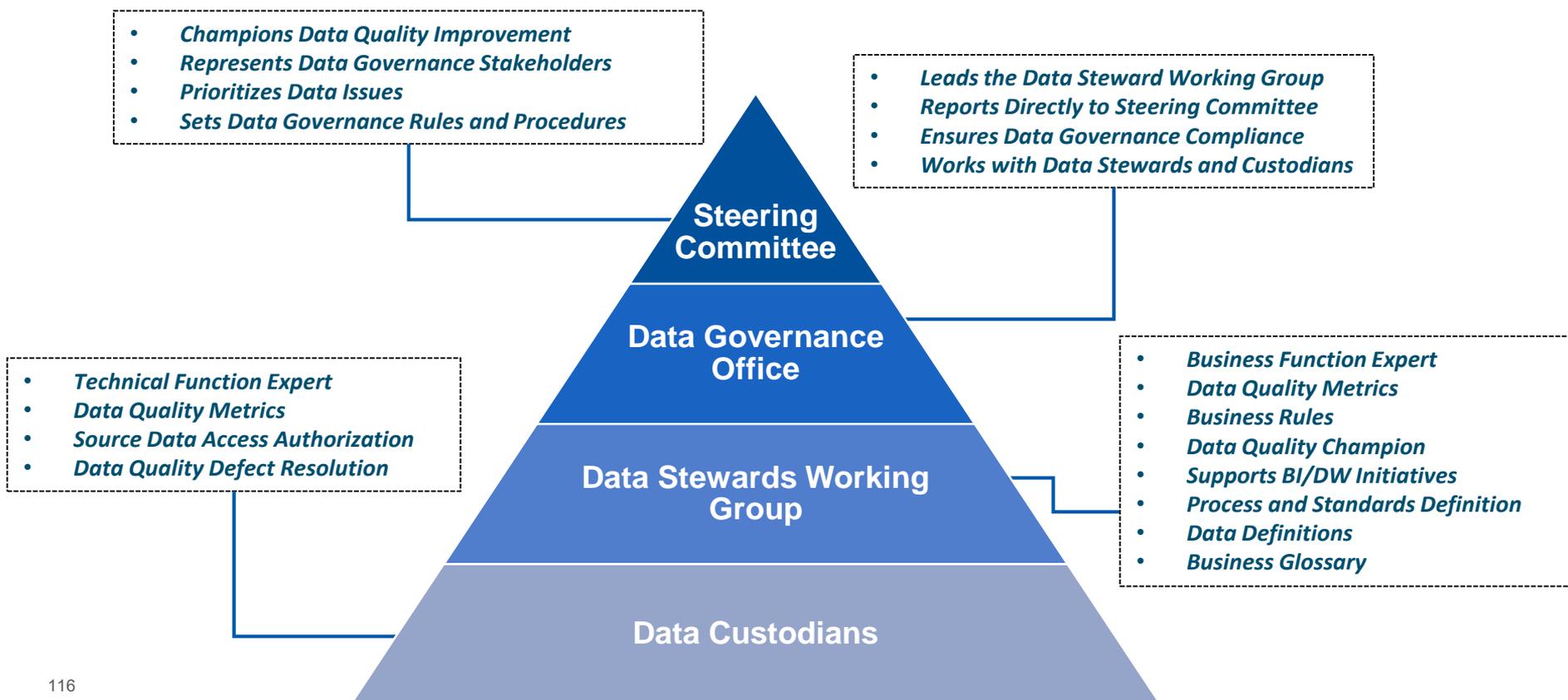
**Technology:** Technology solutions are required to provide common standardized Business Intelligence (BI) / Data Warehouse Tools, technologies and frameworks that will be used across organizations to make data/information more accessible.



## DATA GOVERNANCE ORGANIZATION & STRUCTURE

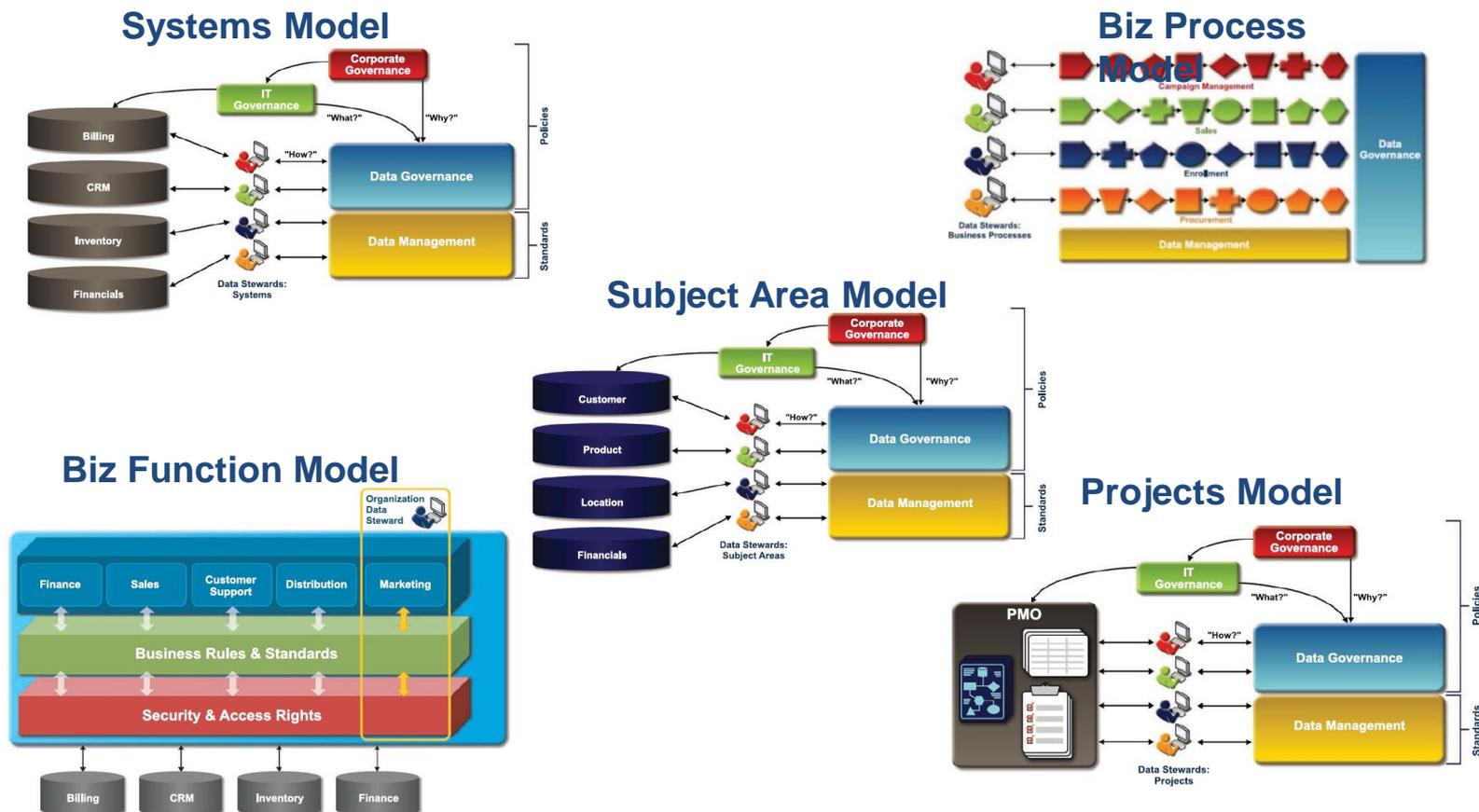
Data governance involves decision-making, management, and accountability related to the data in an organization, or in the case of the future data sharing initiative, a system of organizations. Often, a data governance structure is built to ensure data will be handled smoothly and effectively and to instill data quality. Data governance programs are designed to prepare rules and regulations for an organization and to handle any issues that may arise regarding data. Data governance structures also ensure compliance with policies. The most crucial step is establishing a data governance structure as it is the foundation for data governance success.

A sound data governance structure and program includes a governing body or Steering Committee, a defined set of procedures, and a plan to execute those procedures. Additionally, data stewards and their teams are tasked with ensuring that data and metrics are defined and managed.



# MODEL OPTIONS FOR THE DATA STEWARD WORKING GROUP

Members of the data steward working groups are manager-level or above individuals who liaise between the Coalition and information technology (IT) team. They drive the data management and data quality for specific subject areas and have subject matter expertise for both the Coalition and IT issues. Identifying the governance structure that best matches the objectives of the Coalition is critical for the data sharing program's success. The following data steward working group models and industry standards were evaluated relative to the Coalition's stated objectives for data stewardship, and it was determined that the Subject Area Model provides the best alignment with those objectives.

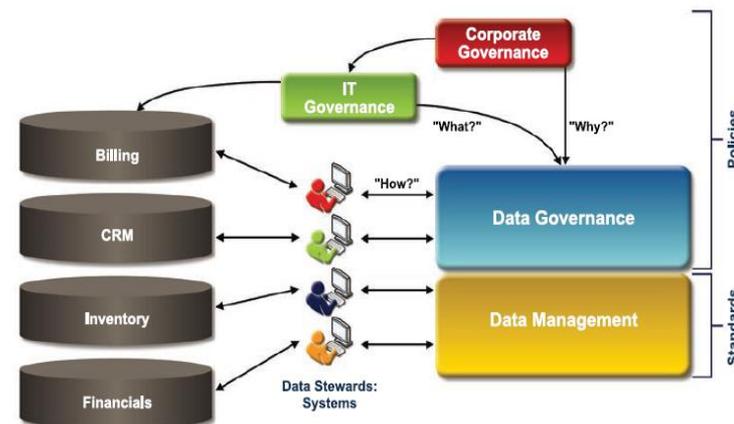


## SYSTEMS MODEL

The systems model assigns stewards to systems that generate the data managed. This is a very technology-centric model; however, many times the systems of origin are the culprits of poor data quality.

### The benefits of system-oriented data stewardship include:

- The technical team is able to take a leadership role in data improvements in cases where the business is unfamiliar with data governance and stewardship.
- System-driven data stewardship can also drive data governance from the bottom-up, allowing the technical team to educate the business about the rules and policies it needs to make the data more useful to the business.
- Assigning multiple data stewards at once is more realistic. The IT mentality that “each core system will have a data steward” becomes an established practice, demonstrating a focus on quality that can, in turn, invite closer alignment between the technical team and business organizations.



### The risks of system-oriented data stewardship include:

- Business people may equate data ownership with data stewardship, thus assuming stewardship to be “a technical issue” and demurring from conversations about policies and usage.
- Data stewards can become myopic as they maintain the integrity of the data on its systems according to specific processing needs and rules. A business-driven data governance model is vital.
- A systems orientation doesn’t ensure data sharing or reconciliation. Data stewardship at the system level doesn’t mitigate the need for data quality, MDM or data integration solutions.

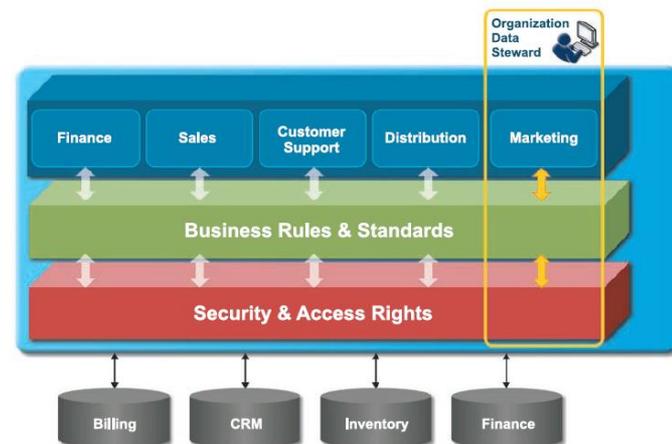
**Conclusion:** This model may not be the best fit for the Coalition as the participating entities have their respective IT systems and the majority of Lake County organizations are on different platforms, with the exception of a few organizations, such as the hospitals that use EPIC or Cerner and community organizations that use Service Point.

## BUSINESS FUNCTIONAL AREA MODEL

The business functional area model is an organizational directed data stewardship design as it focuses on the individual department or line of business using the data.

### The benefits of a functional data stewardship model include:

- A data steward's scope is bounded by the organization, which makes it easier for the data steward to establish definitions and rules, and mitigates the need for complex workflow.
- It's more likely that a data steward from within an organization will be business savvy and familiar with the data's context of usage.
- Functional data stewards that are naturally affiliated with business objectives of their departments, making it easier to delineate and socialize responsibilities.
- A data steward that is likely to know the business users of the data.



### The risks of functional data stewardship include:

- In less structured environments, multiple data stewards in different departments may be managing and manipulating the same data. This results in duplication of effort or conflicting policies and definitions.
- The nature of this model means that data stewards are rarely motivated or incented to collaborate with their peers across functional boundaries, thereby creating conflicting or redundant data silos.
- Functional data stewardship won't work in organizations that have prioritized enterprise-class "single view" initiatives or consolidation programs. It requires strong differentiation in terms of rules, processes, and procedures within individual departments, especially those that are not tied together at the corporate or fiscal level. For this reason, it requires a solid data governance environment.

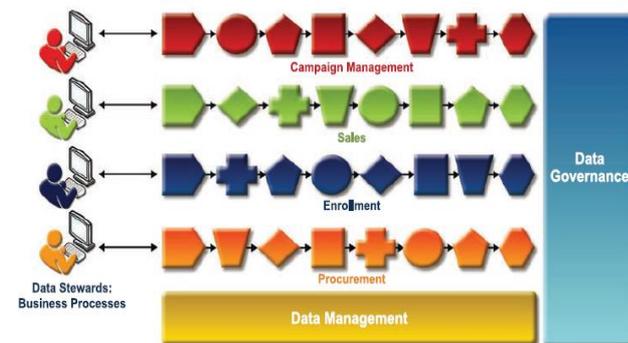
**Conclusion:** This model may not be the best fit for the Coalition as the entities do not share the same business functions. Each entity has defined its own set of business functions unique to its own organization. Additionally, functions can differ across the sectors within the coalition.

## BUSINESS PROCESS AREA MODEL

In this model, data stewards are assigned to a business process. This model is very effective for organizations with a solid sense of enterprise-level processes.

### The benefits of process-oriented data stewardship include:

- Organizations become very comfortable circumscribing their business processes. Data stewardship is therefore seen as a natural extension of process definition.
- Success measurement is more straightforward. Measuring data quality or availability in the context of the business process that consumes the data is a reliable and easy-to-explain the benefit of data stewardship.
- Once an organization launches data stewardship for business processes, it is easy to justify additional data stewards for other processes. The process-oriented model is a very effective way to integrate data stewardship.



### The risks of process-oriented data stewardship include:

- Data ownership is more difficult to assign. Because multiple processes use common data (or should), multiple process owners may have different definitions or rules for the same data.
- Business constituents can get confused. Just as several business processes can use a single data element, multiple business processes can involve the same business community. Depending on the size of the organization and the complexity of its data, several different data stewards could solicit input from a single end-user.
- In this model, data stewardship is only as effective as the company is clear about its processes. For cultures where processes are non-existent or in its infancy, process-based data stewardship may not be the best choice.
- Behind closed doors, some companies will admit that the owners of their operational systems are not accountable for—indeed, many are simply unaware of—the data they generate.

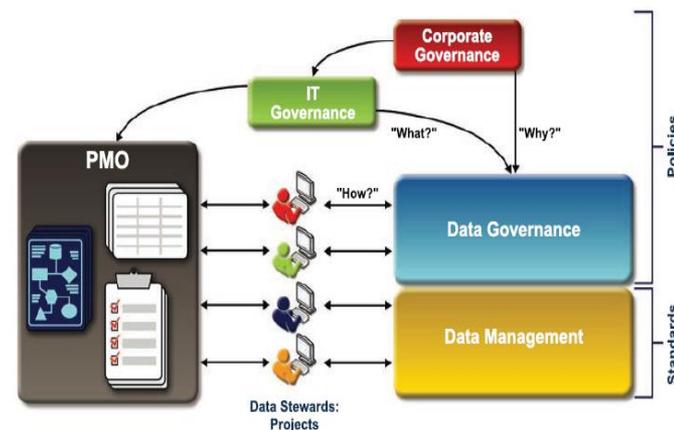
**Conclusion:** This model may not be the best fit for the Coalition as organizations do not share the same business processes. Each entity has defined its own set of business processes unique to its organization. Additionally, processes can differ across the sectors within the coalition and the service providers within those sectors.

## PROJECT ORIENTED MODEL

A project-oriented approach may be a practical and fast way to introduce data stewardship although this is often a temporary measure.

### The benefits of project-oriented data stewardship include:

- Speed. In cultures that take months to justify headcount, the role of a project data steward can be introduced quickly without fanfare and job requisitions.
- Initial data stewardship processes can be tailored to the project's desired outcome, then subsequently refined for broader deployment.
- The success of data stewardship can be tied to the success of the project. While this could be seen as both a benefit and a risk, the ability to tell a story about the project's information delivery can be immensely helpful in communicating the value of data stewardship to a broader audience.



### The risks of project-oriented stewardship include:

- A "project" implies a finite effort, implying that data stewardship is finished when the project is complete.
- Finding incumbent skills can be challenging. Ironically, it is the organizations that use project-oriented data stewardship that lack people who are proficient in solid data skills.
- Any data stewardship processes or technologies adopted within the context of project data stewardship may not be valuable to more enterprise-class data stewardship efforts. Positioning project data stewardship as a pilot helps.

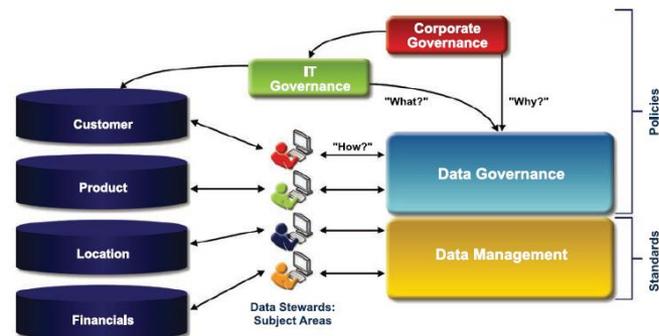
**Conclusion:** This model may not be the best fit for the Coalition as the entities do not share projects. Each entity has defined its own set of projects unique to its own organization.

# SUBJECT AREA MODEL

With this structure, data stewards own and manage a discrete data subject area.

**The benefits of a data subject area oriented stewardship model include:**

- Ownership boundaries that are usually clear.
- The data steward's knowledge of the accompanying business rules and usage environments for his/her data subject area are likely to increase over time.
- This model is often easy to understand and explain, thus reduce resistance during implementation



**The risks of data subject area stewardship include:**

- The potential size and scope of a given data domain – across multiple stakeholder organizations, processes, and data sources – may make finding qualified data stewards challenging.
- Subject area data stewardship can be territorial, especially if system owners refuse to cede control.

**Conclusion:** This model may be the best fit for the Coalition as the goal will be to bring data in from many different entities and disparate systems:

- The data will be brought in, integrated, and normalized along key subject areas of interest to all coalition members.
- The coalition will be best served to have data stewards who have the knowledge and expertise to provide standards and definitions in each of the subject areas.

## ROLE OF DATA GOVERNANCE

The role of data governance will be more important for the Coalition due to the number of different stakeholder organizations and systems that will be involved with data sharing. Not only are the systems, potentially, unique to each stakeholder organization, but the definitions of terms and business rules may be different for each stakeholder organization. Thus, in order to bring all the organizations in the Coalition into alignment, data governance plays a key role in following ways:

- Define, approve and communicate data strategies, policies, and standards
- Set common definitions for metrics, data elements, and business rules which provide consistency across the Coalition
- Track and enforce conformance to data policies, standards, architecture, and procedures
- Sponsor, track and oversee the delivery of data sharing projects
- Manage and resolve data related issues for the Coalition

## 3.1.6 DATA SHARING AGREEMENTS

Data sharing agreements are leveraged to assist organizations, or a group of organizations, to outline the terms and commitments of sharing data with one another.

There are many types of agreements with varying content that can be used to address the specific nature of a data sharing arrangement.

It is important to note that not every instance of data sharing requires that an agreement be signed. For example, healthcare providers connecting with one another on a continuum of care on behalf of a patient do not need to draft and sign an agreement each time to share data as their license and authority under federal law allows the sharing of select information. On the other hand, project –oriented data sharing, such as grant-driven data sharing or one-time studies, may warrant an agreement between participating parties. The language for agreements, if a document exists, can be strongly customized to the task at hand, as opposed to the more formal and standard language included in data sharing agreements that support an on-going process or engagement. Organizations’ risk and compliance counsels often own and agree to the contents of data sharing agreements and some example data sharing agreements are located in the Appendix in *7.7 Example Data Sharing agreements*.

Data sharing agreements can be an effective tool for encouraging cross-organization collaboration and the type of agreement utilized should match the needs of the Lake County behavioral health community as it develops its data sharing model. As Lake County stakeholders and the behavioral health community move forward with implementing data sharing, multiple data sharing agreements may be needed throughout the life cycle of the development.

Organizations that participate in a data sharing model can leverage their experience with grant and vendor agreements to identify the standard and custom language their organizations include in data sharing agreements and evaluate whether to integrate those into a system wide data sharing agreement. Documents that could be used for reference to create data sharing agreements include ServicePoint’s *User Policy, Responsibility Statement & Code of Ethics*, existing point-to-point or grant-related agreements, and comparable community agreements. Example data sharing agreements are located in *Appendix 7.7 Example Data Sharing Agreements* and could be used in the future as a starting point for drafting the Lake County behavioral health community’s agreements.

The following slides provide an overview of the types and content of data sharing agreements that could be employed by Lake County for its data sharing initiative.

North Highland’s recommendations for Data Sharing agreements within Lake County are included in section *5.1 Recommendations*.

## DATA SHARING AGREEMENT TYPES

Below is a description of the types of data sharing agreements that organizations have employed to establish and commit to programmatic data sharing.

**Memorandum of Understanding (MOU):** An MOU is used during the early phases of a data sharing initiative. It can be used prior to a formal Data Sharing Agreement to outline the goals of the initiative and commitment to work together. It can further articulate roles and responsibilities for moving forward a full data sharing initiative as well as expected ways in which the parties can participate.

**Data Sharing Agreements:** Data sharing agreements outline: the data to be shared, responsibilities of the sending and receiving parties (operations, frequency, and process for sharing data), the security of the data storage and type of data (de-identified, MPI processes, etc.), terms and termination, and indemnification. This type of agreement can be used as a mechanism to promote cooperation and trust because of the meticulous details included, namely the data submitted, allowed use, compliance standards, data governance structure, and liability protection.

**Data Use Agreements:** Data Use Agreements outline the use of data by the recipient of any shared data. Often these agreements are used in conjunction with a Data Sharing Agreement and specify that data can on be used for research, public health, or healthcare operations. These documents establish how data can be used (e.g. for analysis, to take action, etc.) and who is permitted to use, have access to, and disclose data sets. This is particularly important when it comes to limited data sets that contain PII or PHI. Data Use Agreements also outline uses cases that are not permitted and promote safeguards, such that receiving entities of the data have the correct security in place.

**Business Associate Agreement (BAA):** A business associate agreement (BAA) is a contract between a HIPAA-covered entity (Health Insurance Portability and Accountability Act) and a HIPAA business associate(BA). The contract protects personal health information (PHI) in accordance with HIPAA guidelines. Covered entities are defined in the HIPAA rules as (1) health plans, (2) health care clearinghouses, and (3) health care providers who electronically transmit any health information in connection with transactions. A “business associate” is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity.

## DATA SHARING AGREEMENT TYPES

**Participation Agreement:** These agreements are designed to ensure that parties sharing data comply with the agreed-upon policies and procedures, and often outline the relationships and responsibilities of each party relative to the data sharing activities and agreement. The purpose of these agreements are very similar to Memorandum of Understandings, although Memorandum of Understanding have a greater connotation of being less binding and can be written in such a way that they promote a commitment to an initiative rather than a formal, legally-binding obligation.

**Service Level Agreement (SLA):** A service level agreement (SLA) is a contract that spells out, in measurable terms, what services a provider will deliver to a customer. Data warehouse SLAs can be employed to outline the areas of quality and components for successful implementation. For the purposes of the proposed model for Lake County, should Lake County contract for a data warehouse and/or analytics tool, Lake County should consider SLA agreements or evaluate vendors' standard SLAs as a part of its contracting process.

**Consent to Release Information:** Commonly referred to as a "Release of Information" is an agreement between the patient and the organization, it is the first agreement required to share a participants' data, and should not be forgotten during the Data Sharing Agreement creation process. The language included in Illinois often refers to the stipulations and specific releases required under 740 ILCS 110 and accompanying information surrounding patients' rights is often provided as well.

## DATA SHARING AGREEMENTS – GENERAL CONTENT

The type of agreement to use within Lake County will depend on each organization's required content and the agreement that best addresses the specific nature of the agreed-upon data sharing arrangement. Any combination of the aforementioned agreements can be utilized and the following are the types of information that should be considered within an agreement or a combination of agreements.

### Data Sharing Agreement Components

- **Definitions** – detailed descriptions of the terms to be used throughout the document.
- **Storage of information** – Who is responsible for collecting, receiving and storing information. Notification that disclosure outside of the program is prohibited and that signatories must comply with the procedures and policies governing the information.
- **Access to information** – the process by which organizations submit data (i.e. HL7 through secure messaging) and the process through which the data is cleaned. This can also include how new entrants are set up (message and communication coding). This section can also be used to define who has access to information.
- **Confidentiality** – language to indicate that the storage, collection and communication mediums must keep the shared data confidential, pursuant to applicable laws and the participant's own internal rules and regulations relating to confidentiality.
- **Administration of the data/Data governance** – outline of the overseeing data governing body and how it enables participants in the data sharing agreement to provide meaningful input and oversight of the operations of the arrangement.
- **Data use** – use cases documenting how the data will be consumed, handled, and analyzed at each participating organization, especially in clinical contexts
- **HIPAA & BAA provisions** – identification and definitions of reasonable safeguards for protecting data within the context of HIPAA application.
- **Indemnification** – an agreement to indemnify one another if damages or expenses are incurred as the result of a data breach or a participant's inaccurate, incomplete or defamatory information.
- **Term and Termination** – defining the causes for which an organization may withdraw or the length of the agreement
- **Misc. Provisions** – This section is leveraged to make sure that any constraints or clarifications that may not be applicable to the other sections are included in the agreement.
- **Non Disclosure-** Common non-disclosure agreement components:
  - Define what is included as confidential and what is not
  - Who has access to the information based on need and compliance with agreements
  - Agreement to abide by HIPAA and the BAA of the coalition
  - Damages and relief language concerning breaching
  - Dispute arbitration settlements

## 3.1.7 DATA PRIVACY LAWS CITED AS BARRIERS

The laws cited as impacting data sharing in Lake County include HIPAA, 42 CFR and 740 ILCS 110. These laws were researched for their applicability to this project and the potential data to be shared within a future data sharing initiative. Individual stakeholder organizations are impacted by these laws to greater or lesser extents and have different policies to address risk. For example, if individual data is inappropriately exposed, a behavioral health provider experiences high impact and high risk; whereas a homeless advocate would have low impact and low risk.

	HIPAA	42 CFR Part 2	740 ILCS 110
<b>Purpose</b>	Balance patient privacy against best treatment options	Protect patient records concerning drug or alcohol abuse	Protect the private information relating to behavioral healthcare and developmental disabilities services
<b>Organizations Affected</b>	All healthcare providers that store or transmit health information	All drug or alcohol treatment providers, be they stand alone clinics, facilities within a larger system, or clinicians with this emphasis	All healthcare providers
<b>What it protects</b>	All individually identifiable health information, psychotherapy notes (requires additional authorization)	Personally identifiable records concerning drug and alcohol abuse or treatment	Documents relating to: physical or mental examinations, diagnosis, treatment, evaluations, medications, aftercare, rehabilitation, notes concerning services
<b>Exceptions</b>	By patient signature, de-identified or aggregate information, specified uses	By patient signature, situations deemed emergent, others	By patient signature (consent must include name of the receiving agency, reason the record is being disclosed, type of record, and date the consent ends); others; no other exceptions for therapists' notes
<b>Level</b>	Federal	Federal	State

# THE HEALTH INFORMATION PRIVACY AND ACCOUNTABILITY ACT (HIPAA)

The Health Information Privacy and Accountability Act provides legislation on the security and data privacy for safeguarding medical information. Prior to HIPAA security standards varied greatly across organizations within the healthcare industry. A primary goal for HIPAA is to protect PHI while allowing organizations to adopt technology to improve the quality and efficiency of service delivery, which can include sharing data stored electronically.

HIPAA treats mental health and all protected health information uniformly with the exception of psychotherapy notes, which include conversational details and are distinguished from the patient's medical record, separately. These notes do not contain any information about medications or prescription management, test results, summaries of diagnosis treatment plan symptoms. These notes are considered separately because they are the personal notes of the professional and as such, a patient authorization must be required to disclose the information. HIPAA also outlines situations for the allowable sharing of needed information with family members or caretakers for the purpose of care. In cases of severe mental illness and a patient is incapacitated, the provider must determine that information disclosure is in the patients best interest. If a provider believes that a patient presents a serious or imminent threat to self or others, that provider may disclose the necessary information to law enforcement, and other persons who may reasonably be able to prevent or lessen the risk of harm. Many states have laws that prevent this disclosure. Hospitals allow the disclosure of information to law enforcement, such as admission and discharge time, to law enforcement for the purposes of locating a suspect, fugitive, material witness, or missing person and this request may be received orally or in writing.

HIPAA-compliant organizations must ensure their data-sharing partners are also HIPAA-compliant. Of the rules that data sharing agreements need to comply with, HIPAA is frequently cited as easier to address.

HIPAA is perhaps the most well-known data privacy law within Healthcare. This law has been criticized for some of its vague language and as such additional, more strict laws have been created to clarify the confidentiality requirement and allowable data sharing. These stricter laws may be the reason that HIPAA is seen as restricting data sharing although its original intent was to promote care coordination and data sharing.

With the introduction of standards and restrictions, especially as additional laws were created stressing confidentiality, many providers have invested significantly in risk and compliance departments to translate these laws into operational practices to ensure technology systems and operations are compliant per each organization's chosen interpretation of the law.

## CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS (42 CFR PART 2)

42 CFR Part 2 outlines the restrictions for sharing data on behalf of an individual being treated for drug or alcohol problems as well as certain diseases. The allowable data sharing described in 42 CFR relates to the disclosure of any information that would directly or indirectly identify a patient as an alcohol or substance abuser or having sought or received treatment for alcohol or substance abuse.

Data sharing includes the communication of patient information, a verification of another person's patient information, or a communication of any information from the records of a patient who has been identified. Examples of identifiable information include name, address, social security numbers, fingerprints, photographs, and any information that may be combined with publicly available information to identify a person.

Specific information about a patient arising out of the patients' diagnosis, treatment, or referral to treatment can be exchanged with supportive services, such as billing, without patient consent. If an individual has an encounter at program treating substance abuse as a part of a larger behavioral health program or general health program, confirmation of an encounter is allowed so long as it does not identify the treatment received as drug or substance abuse related.

42 CFR applies if patient information is being submitted, stored, exchanged through, and analyzed by a health information organization (HIO) and this disclosure is only allowed select purposes. To share data requires that patients sign a Consent to Release Information form and that there is an agreement in place between the substance abuse program program and the HIO.

Consent to Release Information forms should include the following information:

- Name and title of person or program permitted to make the disclosure
- Name of the patient
- Purpose of the disclosure
- How much and what kind of information can be disclosure
- Patient and/or guardian signature
- The date
- Statement that the consent is subject to revocation at any time
- Expiration date which should be no longer than the reasonably necessary time to serve the purpose for which it is shared
- If information is shared electronically, an electronic disclosure must also be sent that the information cannot be redisclosed

For the HIO to redisclose information to its affiliated participants, another patient consent form may be needed. If the purpose of the disclosure to the HIO and the HIO's affiliated partners is the same, then a single consent form that includes the identification of the affiliated receiving parties and a notification on the prohibitions on disclosure is sufficient.

42 CFR also stresses that the sharing of information should be in the best interests of the patient, and as such it outlines allowable purposes and that only the needed information should be shared for the reasonable amount of time to address the care need.

In the case of medical emergencies where a patient consent is not warranted, the provider receiving the information and the context of the event must be documented in detail should the scenario warrant subsequent investigation.

# MENTAL HEALTH AND DEVELOPMENTAL DISABILITY CONFIDENTIALITY ACT (740 ILCS 110)

740 ILCS 110 outlines the allowable data sharing scenarios under which information from patient records for individuals with mental health and developmental disability may be shared in Illinois. This act is more strict than HIPAA, taking precedence over HIPAA's outlined allowable sharing of data.

Similar to 42 CFR Part 2, 740 ILCS 110 stresses that only the data that needs to be shared for the purposes of the data sharing effort at hand should be communicated (i.e. data needed for a particular study). Blanket consent to the disclosure of unspecified information is not valid. The re-disclosure of information is prevented under this act as well.

Under 740 ILCS 110 every consent form must be in writing and include the following:

- The person or agency to whom the disclosure is to be made
- The nature of the information to be disclosed
- The right to inspect and copy the information to be disclosure
- The consequences of a refusal to consent, if any
- The calendar date on which the consent expires (if not date is provided, information may only be released on the date the release form is received by the therapist)
- The right to revoke the consent at any time

Furthermore, the consent to release information, and any revocation of consent, must be signed by a person entitled to give consent and the signature must be witnessed by a person that can verify the signee's identity. A copy of the consent must then be added to the patient record.

The act also highlights when disclosure can occur without a patient consent, including data sharing across agencies or departments of the state, Law enforcement investigations, Court cases in which mental health is a part of the claim, and the sequencing of required subpoenas to release information if needed.

Care coordination needs require that the disclosures be signed however since care coordination can occur across a host of service providers and for varying purposes, as defined by each organization in accordance with its interpretation of the law, no standard release form can exist. Furthermore, the mandate to have the information in writing and with a witness can make attaining signatures difficult.

## HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH)

In addition to the three laws cited during the Current Data Sharing Assessment interviews, a fourth law, Health Information Technology for Economic and Clinical Health Act (HITECH), is applicable to this Data Sharing Project. The law outlines the allowable data sharing of electronic PHI which impacts organizations, specifically healthcare organizations, ability to share participant-level information.

HITECH was enacted in 2009 to support meaningful use and the adoption of EHR systems among providers. The HITECH act widens the scope of privacy and security protections, increases the potential legal liability for non-compliance, and provides for more enforcement. To support meaningful use, HITECH outlined violations and penalties for electronic data sharing noncompliance for providers and extended those to business associates as well. It also mandates the notification of a breach for non-secure, or non-encrypted, PHI.

HIPAA requires that non-routine disclosures are documented and with the introduction of HITECH, all disclosures must be accounted for including those for treatment, payment, and healthcare operations. Capturing this information is often done electronically and requires specific functionality within the EHR or a complimentary program, such as access rights and recording the medical files accessed per user. When data sharing is warranted, HITECH emphasizes that only the minimum necessary information should be shared to avoid over-sharing or providing irrelevant information. A common criticism of the HITECH act is that it does not define the minimum necessary information and leaves that to the interpretation of the provider. This can result in the information being shared during an episode of care across providers being different with each interaction. If participant-level information is needed in a data sharing model for Lake County, organizations will need to come to an agreement on the minimum necessary information to share data.

HITECH also developed certifications for compliant technology to assist providers in making sure their programs were compliant and further promote the adoption of electronic data storage and sharing. As the future data sharing model for the Lake County behavioral health community is developed, the Lake County behavioral health community should look for HITECH certified technologies.

## 3.1.8 DATA PRIVACY PRACTICES

### PRIVACY IMPACT ASSESSMENT OVERVIEW

Titles II and III of the Federal E-Government Act of 2002 require that agencies evaluate all systems that collect personally identifiable information (PII) and determine whether the privacy of that PII is adequately protected. Agencies perform this evaluation through a privacy impact assessment (PIA), a tool for identifying and assessing privacy risks throughout the development life cycle of a program or system. A PIA will state what personally identifiable information (PII) is collected and explains how that information is maintained, how it will be protected and how it will be shared.

#### A PIA will identify:

- Whether the information being collected complies with privacy-related legal and regulatory compliance requirements
- The risks and effects of collecting, maintaining and disseminating PII
- Protections and processes for handling information to alleviate any potential privacy risks
- Options and methods for individuals to provide consent for the collection of their PII

#### A PIA should be completed when any of the following activities occur:

- Developing, or procuring any new technologies or systems that handle or collect personal information.
- Developing system revisions. If an existing system is modified, a PIA may be required.
- Initiating a new electronic collection of information in identifiable form for 10 or more persons, consistent with the Paperwork Reduction Act (PRA).
- Issuing a new or updated rulemaking that affects personal information. A PIA is required for collections of new information or updates to existing collections as part of a rulemaking. The PIA should discuss how the management of these new collections ensures conformity with privacy laws.

**The following slide has an initial PIA for the Coalition and the organizations participating in a data sharing model. As the strategy and solution for data sharing evolves, the Coalition and the organizations that participate in data sharing should re-visit the PIA during each phase of the planning, development, and implementation to ensure that proper process and technology safeguards can be implemented.**

Sources include: <https://www.hhs.gov/about/agencies/asa/ocio/cybersecurity/pias-and-resources/index.html>, <https://www.hhs.gov/pia/index.html>

# PRIVACY IMPACT ASSESSMENT

## Overview

The following is a high-level privacy impact assessment for the future Data Sharing Project. Initially, the data shared will be in aggregated form without reference to PII. However, plans include sharing, obtaining, storing, and reporting on data at the individual participant-level, containing PII, which will require mitigation strategies to address certain inherent risks of sharing data.

## Identify the information the future application collects, uses, disseminates, or maintains.

The future system will collect and store PII (name, birthdate, address, etc.), as well as physical and behavioral health record information. In addition, there may be related law enforcement, court, and probation related data containing PII.

## What are the sources of the information and how is the information collected?

The data will be provided by the various organizations and stakeholders participating in the Data Sharing Project. Once the Data Governance body and Data Steward Working Groups determine the requirements for data to be shared and collected, the agreed upon data must be prepared for transmission. The Data Governance technical team will need to determine the best method to transmit data between organizations, whether that is thru secured email or Secured File Transfer Protocol (SFTP).

## Privacy Impact Analysis: Related to Characterization of the Information

- **Privacy Risk:** The data collected is required for the Data Sharing Project. As in any situation where data is shared, there is a risk of interception or disclosure.
- **Mitigation:** If organizations choose to submit their data via email, it is recommended that the data be encrypted before sending to protect the information while in transit. A standard method is to use SFTP, along with data encryption, as SFTP is a secure point to point transfer vehicle.

# PRIVACY IMPACT ASSESSMENT

## Privacy Impact Analysis: Related to the Uses of Information

- **Privacy Risk:** There is a potential risk of capturing PII during the transfer of data between the source organization and the target when loading the data into the central repository (data warehouse).
- **Mitigation:** With the assistance of the Coalition's Data Governance Board, MOUs and Data Sharing Agreements should be set up between the organizations sharing data that outline the security measures, auditing, and roles and responsibilities for handling the data. The number of individuals with administrative access to the future environment should be managed through an approval process. All administrators of the infrastructure and databases should be pre-approved and be trained in system administration and security measures.

## Privacy Impact Analysis: Related to Information Sharing

- **Privacy Risk:** Information sharing may place participants/patients at risk of harm if disclosed or used by unauthorized people or uses.
- **Mitigation:** As discussed above, MOUs and Data Sharing Agreements will govern the use of the data. Additionally, the Data Governance Board and Data Stewards can limit the participant-level data shared when referencing an individual during use to limit the exposure potential and to decrease the risk of harm to the participant.

## IDENTIFICATION OF SOPS & SECURITY PROTOCOLS

In general, within the entities of Lake County, North Highland found that there were limited number of standard operating procedures (SOPs) as data sharing was at a minimum; and where it does exist, the SOP is largely outlined by the grant requiring it.

Strategies that organizations storing PII and PHI data employ to meet data privacy requirements include what hospitals with EMRs and those entities using shared applications with PII data employ:

- Required HIPAA training for personnel obtaining access to PII and HIPAA covered data
- Workstations and applications requiring password security for access to data
- “Break the glass” acknowledgement and verification, usually twice, of individual has authority and valid reason for accessing specific patient level data
- Audit traceability to view who had accessed and view individuals’ PII data
- SOPs and policies for handling situations where there have been lapses in security protocols or inadvertent sharing/disclosure of PII and HIPAA covered data.

**HIPAA training, SOPs, and security protocols need to be developed and rolled out in advance of when personally identifiable information and participant-level health data are to be shared amongst the stakeholders of the Coalition.**

A link is provided to the HHS.gov website (<https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html>) where segments of the Summary of the HIPAA Security Rule are shared. This is a summary of key elements of the Security Rule including who is covered, what information is protected, and what safeguards must be in place to ensure appropriate protection of electronic protected health information.

## *3.2 Current Data Sharing Assessment*

## 3.2.1 CURRENT DATA SHARING ASSESSMENT CONTENTS

The Current Data Sharing Assessment was done in accordance with the approach described in 2.3.3 *Current Data Sharing Assessment Approach*. The information collected was largely the product of interviews across Coalition members and the Lake County behavioral health community.

The below pages include the following:

- Overview of the Interview Process and Sector Definitions
- Sector Analysis, including process flow diagrams and strengths, weaknesses, opportunities, and barriers observations
- Current Data Sharing Technology
- Current Data Availability and Existing Partnerships
- Barriers to Data Sharing
- Legal Considerations
- Change Management Status
- Summary of Current Data Sharing

The observations included in the following are highlights from the current data sharing assessment research and North Highland's analysis and were used to conclude the findings listed in section 4. *Data Sharing Project Findings*.

# CURRENT DATA SHARING ASSESSMENT INTERVIEWS

Interviews were conducted across Coalition members and the Lake County behavioral health community to understand how different organizations were documenting information related to behavioral health individuals and to better understand what data points were received, collected, and shared within and between organizations and how that information was shared. Interviews were conducted with a diverse set of Lake County stakeholders across functional and technical expertise, front-line, and executive staff and across various service providers. Below is a description of the interview questions, and in the Appendix is a list of the individuals interviewed and the interview guide used to facilitate the discussions.

## INTERVIEW APPROACH

Interview discussion topics focused on processes and services, data sharing, technical specifics, barriers to sharing data, and benefits of improved data sharing practices. The research provided and answers collected informed a “SWOB” Analysis: Strengths, “What’s in it for me,” Opportunities, and Barriers to data sharing.

## QUICK STATISTICS

**65**  
INTERVIEWEES  
**20+**  
ORGANIZATIONS

## PARTNER TITLES

Psychologist	Nurse
Social Worker	Probation
President	Sheriff
Office Manager	Assistant Director
CEO	Police Officer
Psychiatrist	Police Chief
CIO	Doctor
Director	External Affairs
Volunteer	Chief Operating Officers

## EXAMPLE INTERVIEW QUESTIONS

FUNCTIONAL

What is the process for a participant going through your system?  
How do you determine the need for services?  
How and what information is sent to and from partner organizations?

What operational, technical, or legal barriers permit or allow you to share data?

TECHNICAL

If data is sent electronically, what message format is that information in?  
What data points do you collect?  
What reporting capabilities does your organization have?  
How is data aggregated?

## SECTORS

### HEALTHCARE



Health and Behavioral Health Centers



Hospital

### JUSTICE



Police



Courts, Probation



Sherriff Jail

### COMMUNITY



Community Organizations



Homelessness Groups

## SECTOR DEFINITIONS AND PURPOSE

As interviews progressed, common themes and answers surfaced in organizations with similar functionality. For instance, organizations with healthcare delivery as a core competency utilized similar methods of communication (fax) and expressed similar concerns regarding privacy laws. These groupings helped categorize feedback and organizations so that information could be synthesized and presented in a digestible way. Breaking feedback into sectors also provided greater insight into the continuum within each sector and highlighted the critical roles each sector plays in the care of individuals with behavioral health needs. The following are the three sector types.



### HEALTHCARE

#### Healthcare providers include:

- Hospital services
- Primary care
- Health centers
- Substance abuse testing and counseling
- Psychology & Psychiatry services
- Outpatient or clinic services
- Behavioral health therapy
- Inpatient care
- Crisis response
- Screening

**ORGANIZATIONS FELL INTO THIS SECTION IF THEY PROVIDED ONE OF THE FOLLOWING SERVICES:**

**INTERVIEWEE ORGANIZATIONS INCLUDED:**

Vista Hospital, North Shore community Hospital, Northwestern University Hospital, Erie Family Health Center, Lake County Health Department, Youth and Family Counseling, Mental Health Initiative, NICASA, Community Youth Network



### JUSTICE

#### Members of the justice system

- Enforce the law
- Protect the people from harm from others or themselves
- Evaluate, defend, prosecute, in court
- Process, enter, and disseminate necessary information regarding a case pertaining to an individual with behavioral health needs
- Provide back office support services for the operations of the justice system including police, sheriff, jail, and courts

Police Officers, Sheriff's Department, Jail, Courts, State's Attorney



### COMMUNITY

#### This sector includes but is not limited to the following:

- Advocacy groups for individuals with behavioral health
- Intervention and early education programs that build awareness of behavioral health
- Organizations that address the societal factors that can compound or that are compounded by behavioral health
  - Housing
  - Religion
  - Employment

Workforce Board, PADS, LCHRDC, Mental Health Initiative, NAMI, Lake County United, NICASA, Youth & Family Services, A Safe Place, community Youth Network

**ORGANIZATIONS PROVIDING MULTIPLE SERVICES COULD FALL IN MORE THAN ONE SECTOR.**

## 3.2.2 SECTOR ANALYSIS

An analysis was conducted of the information in existing reports, the information collected from functional and technical interviews (pertaining to the interviewee's knowledge of behavioral health, programs, data and analytics and technology) to assess the current data sharing practices within the Lake County behavioral health community by sector.

The results of the research, interviews, and known best practices are outlined in the following slides. The slides convey the following types of information for each sector:

- A profile slide to highlight the roles each sector can have in behavioral health
- A process map outlining the flow of data and the medium through which data is shared (if data is shared)
- An analysis of key factors influencing data sharing called a “SWOB” analysis (strengths, weaknesses, opportunities, and barriers)

## 3.2.2.1 HEALTHCARE SECTOR ANALYSIS

### HEALTHCARE ORGANIZATION PROFILE

Healthcare organizations have more routine and frequent interaction with individuals with behavioral needs that are seeking services and is well positioned to design intervention programs and to coordinate with others as a part of a care team to ensure that the entire health of an individual is being addressed, in addition to the direct healthcare services provided, such as the societal determinants of health.

#### ROLE

- Provide a full range of services to meet the medical and behavioral needs of a community
- Act as a main point-of-contact and referral source for the mental, emotional, and behavioral health population
- Assess and provide treatment and recovery support services that empower individuals and families to attain their highest functioning possible in all aspects of their lives (school, work, relationships, health, wellness, etc.) and to live independently in the community to the extent they are able.

#### QUICK FACTS

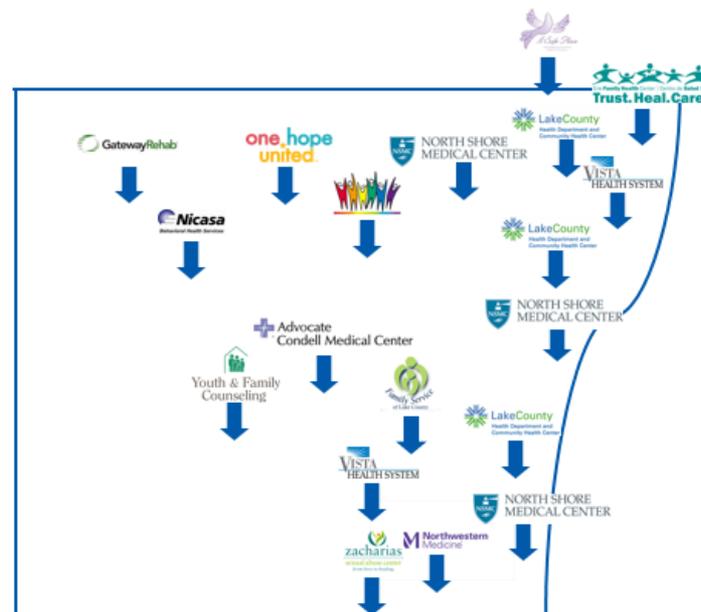
- 1-in-5 Americans has a behavioral health issue of some magnitude
- Medical costs for patients with underlying mental, emotional, or behavioral health needs are 3x the national average of those without mental, emotional, or behavioral health needs.
- 10.2 million Americans have co-occurring behavioral health and addiction disorders.
- Serious behavioral health conditions have an estimated economic impact of \$193 billion in the US.

#### KEY STAKEHOLDERS

 Hospitals  
(ER, Inpatient, and Outpatient centers)

 Health and Behavioral Health Centers

#### THE FOLLOWING HEALTHCARE ORGANIZATIONS FROM ACROSS LAKE COUNTY PARTICIPATED IN INTERVIEWS.



# HEALTHCARE ORGANIZATION PROCESS FLOW

## Process Flow

The diagram on the following slide depicts how individuals with behavioral health needs flow through the healthcare system, the associated data shared and the mediums in which this data is shared. In summary, individuals enter the healthcare system from various sources, including the judicial and community sectors, self-admitting or from another provider. Hospitals, health centers, and behavioral health providers may have ED, inpatient and outpatient services while entry into the healthcare system can also occur directly through one of these services. Based upon evaluations, patients can be moved to a more appropriate treatment location; this transfer can be associated with high wait times. When patients move into or within the healthcare system, their information is either self-reported, reported by a family member or is communicated via fax or phone. If a patient moves within an organization, their information is stored in an EMR.

## Key Observations

### Functional

- Patients may encounter high wait times while waiting to be transferred to the requisite behavioral health treatment facility.
- Sending patient information to other facilities is typically completed via fax or over the phone, which requires manual entry and creates an opportunity for manual error.
- There is no standard for transferring data to an entity outside of a specific program as fax formats vary and the data included by each program differs, resulting in records that lack information and the full scope of patient history and needs.

### Technical

- North Shore and Northwestern both use Epic, for both medical and behavioral, while Advocate Condell and Vista use Cerner. Advocate Condell uses Cerner for both medical and behavioral data. Vista also uses Athena as their behavioral health EMR, which is not connected with their Cerner system. Most interactions within the hospital system occur electronically within their respective EMRs. However, sharing data electronically across EMRs is not currently possible. Epic and Cerner have modules that allow data sharing between organizations that use their programs, but hospitals elect not to purchase this module in light of other priorities.

## HEALTHCARE ORGANIZATION PROCESS FLOW (CONT.)

### Technical (cont.)

- When a patient is transferred within the same organization, there are situations where the technology platform was designed to limit access rights to patient behavioral health information, as it is protected under various interpretations of the Data Privacy Restrictions.
- Because some information is transferred verbally through referring entities, such as police drop-offs or family members, information is also lost in the data transfer; information entered into the EMR is determined by intake individuals' discretion rather than a systematic method of capturing data.
- Prior to purchasing and implementing an EMR solution, hospitals make sure the system they select either meets or can be built to meet their specific data privacy standards as determined by their respective risk and compliance teams.
- Service Point is used by some behavioral health providers to contain select healthcare information, however, since its core use is not as an EMR, leveraging this tool to store all desired health information was communicated as both difficult and frustrating. This results in some community behavioral providers using Excel to store information, which is far more flexible. The pros and cons of utilizing Excel are described later in this document.



## HEALTHCARE ORGANIZATION “SWOB”

The following diagram outlines the strengths of the healthcare sector as it pertains to data sharing, the benefits or what's in it for me messaging, concurrent opportunities or initiatives that can complement a data sharing initiative, and the barriers perceived. As organizations move forward towards systemic data sharing, the below values of data sharing and the obstacles to sharing data will be analyzed further.

More information on the value of data sharing and the obstacles to data sharing for the healthcare sector is below.

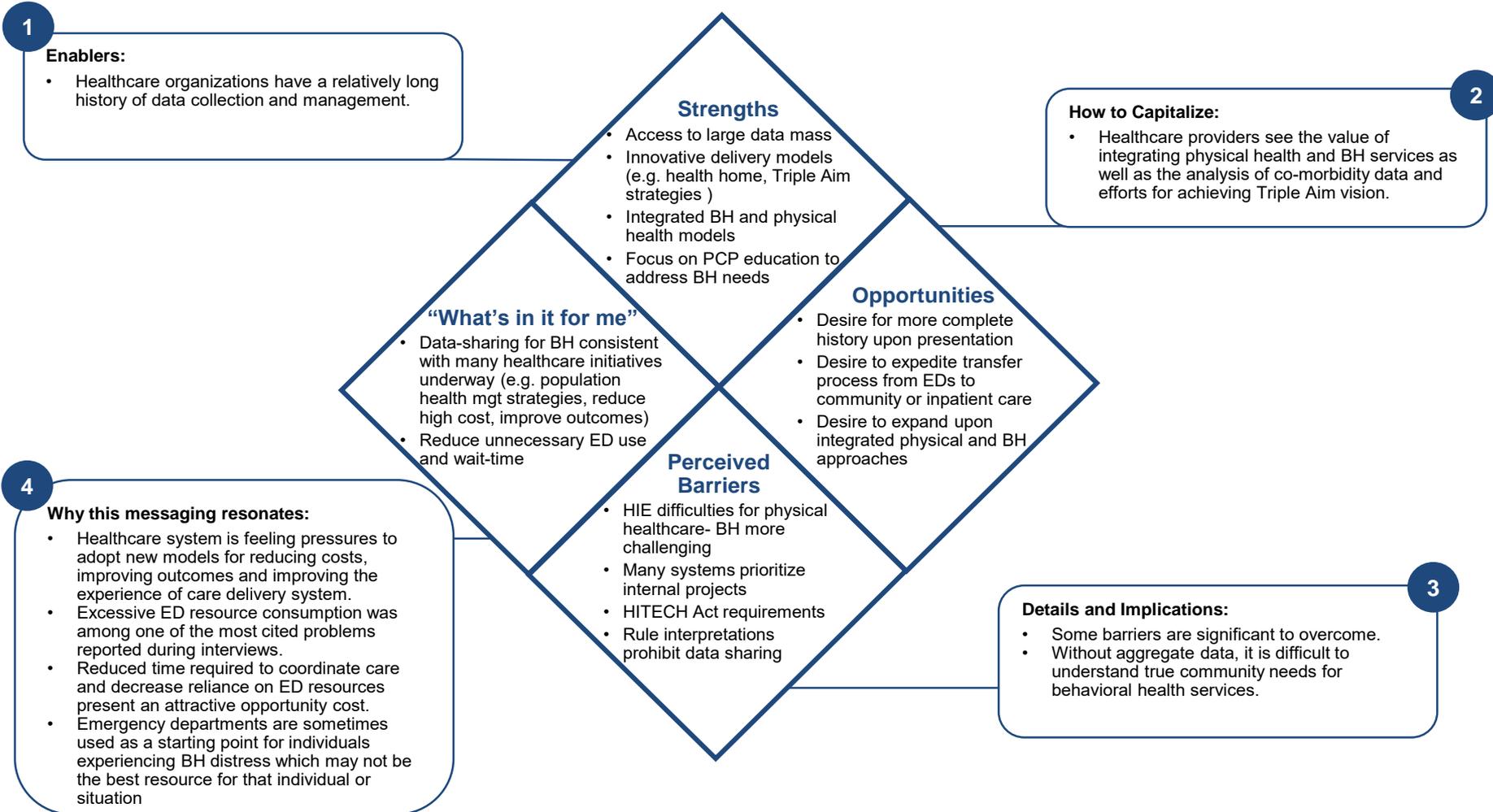
**“What’s in it for Me”:** Healthcare organizations have a clear value to data sharing as they are most familiar with care coordination and know first hand the benefits of the right care at the right time.

- Individuals will be brought to the ED when in crisis or distress, however, there are interventions available before a patient gets to this point that can help provide individuals with the care they need in a more acute setting if the need is known. This coordination would prevent the misuse of ED resources.
- In severe cases, individuals in the ED will remain in the ED for an extended period of time while waiting for an inpatient bed which is an inappropriate use of ED resources, but necessary as that patient is not fit to be discharged and needs additional care
- A coordinated care network can also help providers collaborate more easily on the best place for treatment on behalf of an individual based on that individual’s abilities and needs. This would minimize the time required by organizations to research available resources at various organizations on behalf of a patient and allow more time for providers to deliver care.

**Barriers:** Healthcare organizations communicated barriers to data sharing that were largely focused on compliance.

- **HIE difficulties for physical and especially behavioral healthcare-** Interviewees reported concerns over the success of a central repository for information citing that previous HIE efforts have failed and that it will be impossible to set up a behavioral health HIE when the laws surrounding behavioral health are even stricter. More education around the different possibilities with data sharing is needed to overcome this perception.
- **Many systems prioritize internal projects** – In organizations’ efforts to maintain business as usual and grow organically it was communicated that internal technology upgrades and internal operations can take precedence over external community-wide projects.
- **HITECH Act requirements** - When thinking of a data sharing agreement, the strict compliance rules demanded by HITECH were vocalized as a concern by interviewees as it relates to sharing information with another program. HITECH will certify that the technology program itself is compliant but does not certify that the organizations using a program are compliant.
- **Rule interpretations prohibit data sharing** – varying interpretations of policy and laws across organizations can limit the extent, the content, and the medium with which organizations are comfortable sharing data. Getting organizations to share their data will therefore require significant discussions around the compliance of a future program and the benefits that outweigh the risk.

# HEALTHCARE ORGANIZATION SWOB



## Important Takeaways:

- Physical and behavioral health data at the practice level is shared inconsistently and through telephone and fax.
- There is minimal focus, collection, or analysis of individuals' behavioral health data.
- Some Behavioral health providers do not have electronic medical records.

## 3.2.2.2 JUSTICE SYSTEM SECTOR ANALYSIS

### JUSTICE SYSTEM PROFILE

The justice system will interact with individuals with behavioral health needs in an effort to protect the community and those individuals from harm. To do so, the justice community focuses on ensuring that the appropriate individual handles the incident be it a police encounter, a court case, or a probation officer so that the individual with behavioral health needs is treated appropriately and fairly. Lake County is proactive in their approach to making sure that the justice system is involved on more than a reactionary basis and becomes an integral part of a system-wide network.

#### ROLE

- Sheriff and jails— proactive approach to solving and preventing crime. Incorporates use of CIT (Crisis Intervention Team) approaches to individuals/families with behavioral health needs.
- Jails – place of detainment for a person arrested for a crime until a court makes a judgment. Jails are responsible for the health and safety of an individual in their custody.
- Courts – responsible for upholding the law and resolving criminal, civil, and family matters. Specialty Courts, such as mental health court, drug courts or veterans courts. have been developed to address specific conditions
- Probation – individuals can be assigned to probation as a term of their criminal prosecution. Probation monitors the individual and provides opportunities for rehabilitation including accessing behavioral health services if needed.
- States Attorney- pursues justice through vigorous and ethical prosecution of criminal acts.

#### QUICK FACTS

- The justice system provides services including conducting psychological evaluations, providing counseling to probationers, consulting with probation staff, coordinating referrals and monitoring service contracts with community social service providers
- Provided over 1100 counseling sessions for both juveniles and adults in FY2015
- 16-33% of inmates have a behavioral health condition (as measured by psychotropic drug or psychiatric services)
- Approximately 170 people have been CIT trained in Lake County

Source: Jane Addams College of Social Work- Mental Health Policy, 2015

#### KEY STAKEHOLDERS



Police  
CIT Trained Officers  
Courts



State's Attorney,  
Specialty courts  
Sheriff



Jail  
Probation

#### ILLINOIS INMATES AND MENTAL HEALTH STATISTICS

	Percent of Inmates In:			
	State Prison		Local Jail	
	With mental problem	Without	With mental problem	Without
<b>Criminal Record:</b>				
Current or past violent offenses	61%	56%	44%	36%
3 or more prior incarcerations	25%	19%	26%	20%
Substance dependence or abuse	74%	56%	76%	53%
Drug use in month before arrest	63%	49%	62%	42%
<b>Family background:</b>				
Homelessness in year before arrest	13%	6%	17%	9%
Past physical or sexual abuse	27%	10%	24%	8%
Parents abuse alcohol or drugs	39%	25%	37%	19%

The above graph is provided to highlight the prevalence of mental health needs in jail.

# JUSTICE SYSTEM PROCESS FLOW

## LAW ENFORCEMENT ENCOUNTER

**Process Flow:** When a call is received, 911/dispatch will determine if the call is behavioral health related; if so, it will be noted in the notes within CAD. If the call is behavioral health-related, a CIT-trained officer is requested to the scene, if available. The officer will conduct a CIT assessment – recorded on a paper form (as of 7-29-2017). Given the situation and after reviewing the assessment results, they have three options to pursue: bring the individual to a hospital emergency department, recommend local services for the individual to seek out, or bring the individual through the justice system and to jail. If the individual is brought to jail, a citation is written up (along with an R-code) which is all entered into RMS.

### Key Observations

#### Functional:

- The police encounter is often the first piece of data collected when an incident occurs with a behavioral health individual.
- If an individual is in need and the appropriate services are not rendered at the time of need, the individual may have another encounter shortly after or an unnecessarily escalated encounter.
- When officers are informing individuals of their nearby local services, they may provide them with information via a handout or verbal recommendations based on their knowledge of the individual and available services.
- There is no place within the current Computer Aided Dispatch (CAD) system to denote whether an individual has known behavioral health needs. It is up to the officers' experience to recognize the address of the call given their past encounters.
- While there is an ask to inform police when an individual is being discharged from the hospital, given the demands on emergency room operations, police are inconsistently informed of when an individual is discharged from the hospital.

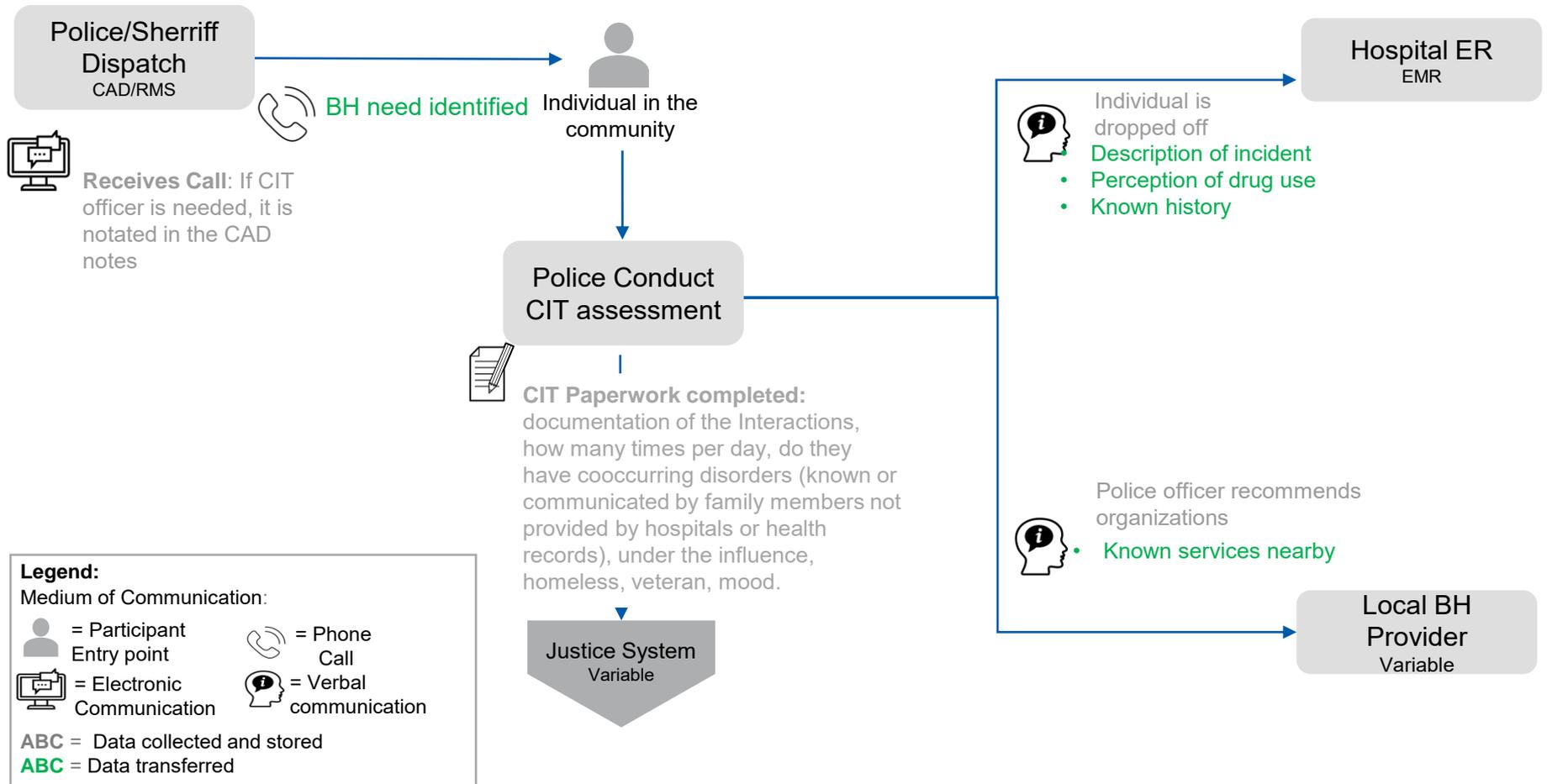
#### Technical:

- 911 and dispatch use CAD systems and with multiple CAD systems in Lake County, it is very difficult to aggregate data. Additionally, if the behavioral health related details are stored in an all text field, such as a notes fields, it is difficult to extract the behavioral health related-information.
- Police and Sheriff's Departments use Record Management Systems (RMS) to capture the citations written by the officers. Given the 43 different Police Departments as well as the Sheriff's Department, there are several RMS systems in Lake County.
- Currently, the CAD and RMS systems do not communicate with one another but there is a consolidation project underway that will help improve communications.
- Calls can be tracked by addresses instead of people, so providing information at a participant-level may require a historical data transfer and restructuring of data collection practices and the technology systems.
- CAD information is owned by the supporting technology system which has the power to do a data dump of information from which reports can be made and analysis can be conducted. No automated report generation process exists to evaluate behavioral health-specific information across systems.

# JUSTICE SYSTEM PROCESS FLOW

## LAW ENFORCEMENT ENCOUNTER

At the time of dispatch, the need for a CIT-trained officer or deputy is determined. At the scene, a CIT assessment is conducted to determine whether an individual needs mental or behavioral related care or treatment. Often times, individuals are taken to the ED but in some cases, they are transferred to a holding cell or the jail.



# JUSTICE SYSTEM PROCESS FLOW

## JAIL & COURTS PROCESSING

**Process Flow:** When an individual is brought to the jail by an officer, a copy of the citation is provided and a Booking Card is filled out. Additionally, a copy of the citation is provided to the Circuit Clerk who enters the information into CRIMS, the court system. If the case appears to be behavioral health related (determined by evaluating additional information), it is assigned to the Mental Health Specialty Court, which will ask for further testing and assessment. After the case goes through court, if necessary, a probation order will be generated. The individual is then asked to take the form with them to their probation officer who will work with the individual to seek and receive prescribed care. If the court orders a bond report to be generated, jail personnel capture the information from the individual using the Digi-pen application (electronically) and printed, then provided to the court.

### Key Observations

#### Functional:

- The most detailed information directly related to the behavioral health of the individual that is collected prior to probation is the lawyer determination to send the individual to the specialty court and any subsequent assessments completed.
- Probation is at an intersection for data as it collects information from outside community members, including where services overlap with healthcare providers, and from the courts. While the probation officers leverage Service Point as a central repository for select information, at the current time it requires double entry which makes operations more cumbersome than need be, creating an additional barrier to data entry.

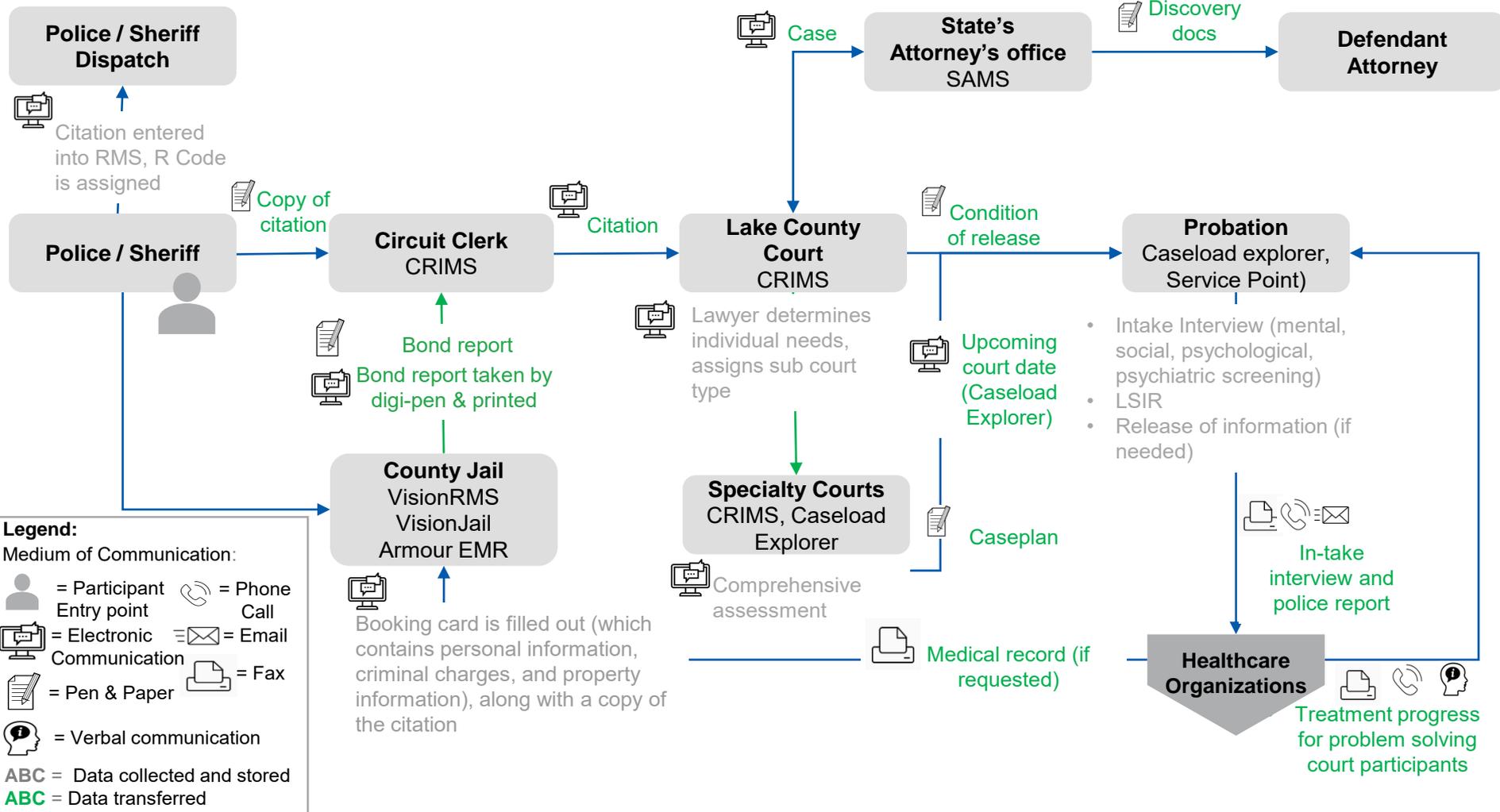
#### Technical:

- Criminal Records Information Management System (CRIMS) is the court program and it contains all court-related documents, but has minimal behavioral health data. The key behavioral health related field is *Sub Court type* which indicates an assignment to Mental Health Specialty Court.
- CRIMS and the other court related systems (Vision RMS, VisionJail, SAMS, etc.) are all connected to the Oracle Enterprise Service Bus system which enables various data to be exchanged by sending XML messages.
- A lack of resources makes it very difficult to generate reports out of CRIMS today.
- Paper forms, manual data entry, and duplicate data entry all pose a greater risk for manual error than an electronically connected communication network for sharing data.
- Probation uses both CaseLoad Explorer and Service Point and both have some behavioral health-related data, but neither is connected with behavioral healthcare providers. If progress updates towards health goals are shared, it is via phone or fax.
- CRIMS was historically organized by case instead of by person, which poses quality and data issues in identifying information by specific individuals. The jail stores behavioral health data in their Armor EMR system and applies a medical record number by person.

# JUSTICE SYSTEM PROCESS FLOW

## JAIL & COURTS PROCESSING

Upon entering the jail, all individuals are given a health assessment. If deemed, an individual will be assigned to the Specialty Mental Health Court. Prior to their court date, additional evaluations can be ordered. As part of their probation order, an individual can be assigned for further treatment/care.



## JUSTICE SYSTEM “SWOB”

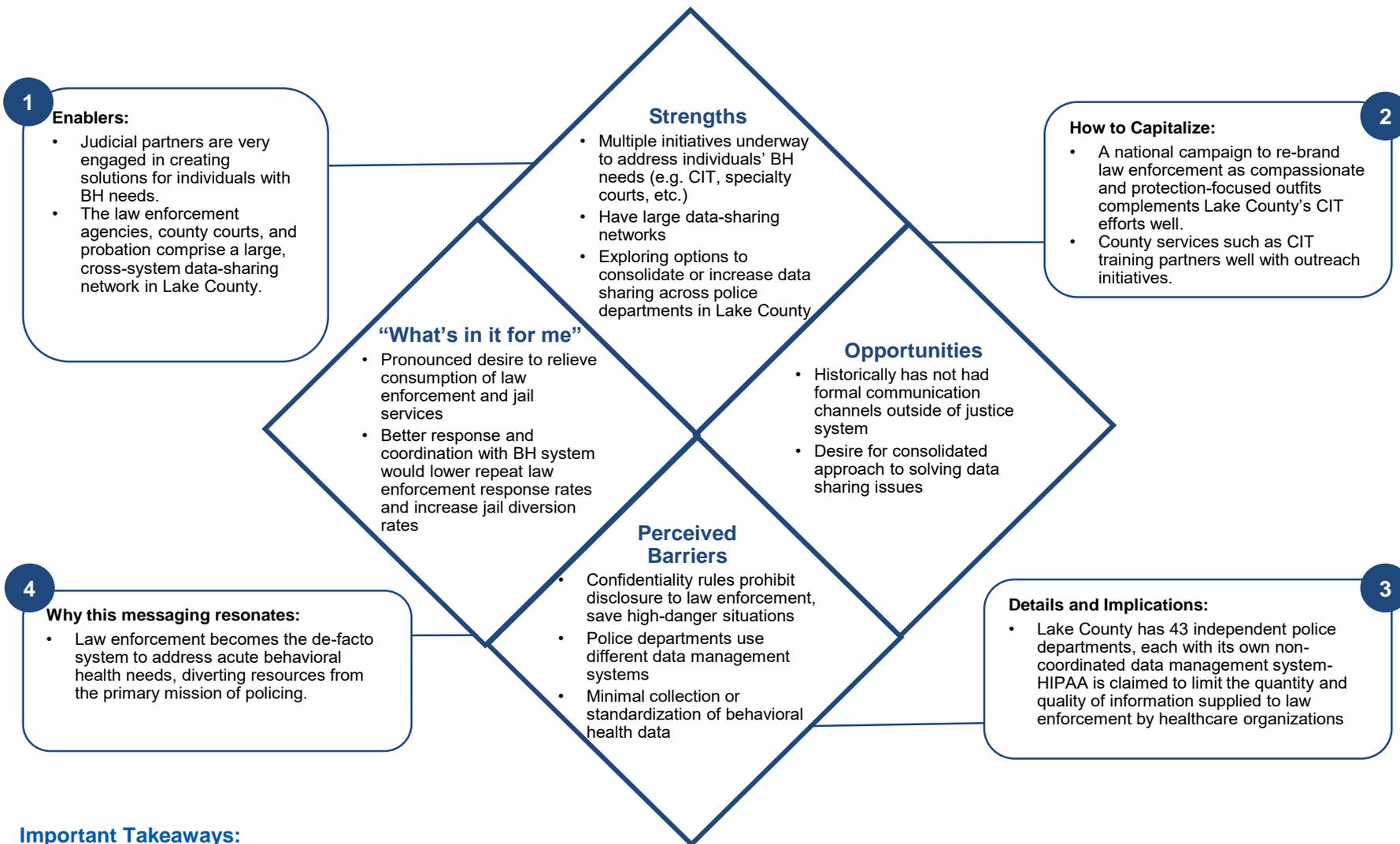
The following diagram outlines the strengths of the Justice System as it pertains to data sharing, the benefits of data sharing to each sector or the ‘what’s in it for me,’ concurrent opportunities or initiatives that can complement a data sharing initiative, and the barriers perceived. As organizations move forward towards systemic data sharing, the below values of data sharing and the obstacles to sharing data will be analyzed further.

**“What’s in it for me”:** The Justice System would benefit from improved data to inform decisions such as the resources needed to appropriately and fairly protect an individual and the community.

- Police are dispatched for issues that arise as a result of not having systematic care coordination and earlier interventions. While these issues may be related to public safety, often the police are the only known resource to come help in a difficult situation.
- Decisions in court are made based on the information that is available and with improved information about an individual’s behavioral health needs, courts can route cases appropriately and prescribe more customized rehabilitation and protective services to the individual to assist the individual in being a productive, engaged member of society.
- Individuals with behavioral health needs in jail are receiving treatment, but the environment may not be the best place for them to be rehabilitated.

**Barriers:** The justice system’s limited connectivity between technology systems and court orders required to share participant-level data make data sharing, especially electronic data sharing, very difficult.

- System reporting is made difficult through the complexity and architecture of CRIMS (i.e. the database was originally designed to be case focused and has since been converted to person-centric, but these legacy issues remain a data quality concern for reporting and search functionality by individual.)
- Probation is required to have a court order to release information which limits their ability to coordinate care on behalf of behavioral health individuals with healthcare and community providers.
- Many technology projects and conflicting priorities currently exist.
- The justice system has relatively less historical data from which to draw analysis on individuals with behavioral health needs.



**Important Takeaways:**

- Even given relatively large data sharing systems within judicial partners, there is minimal data collected regarding behavioral health.
- Service Point is promising for pilot programs to share referrals from Probation to behavioral health providers. The expanded use of Service Point given healthcare providers' need to comply with additional laws, is currently underway.

## COMMUNITY ORGANIZATION PROFILE

No system-wide dating sharing program can exist without the community members that address the societal determinants of health. Community organizations have the unique position of being an unassuming opportunity to identify and build a network of support for individuals with behavioral health needs as they may present themselves for societal services prior to other services, such as healthcare.

### ROLE

- Provide complementary services to behavioral health providers to improve the quality of life and social determinants of health
- Educate individuals with behavioral health needs and the community about identifying, living, and coping with behavioral health
- Advocate for individuals with mental health needs to provide this subset of the population with a voice
- Assist in finding and maintaining appropriate jobs
- Provide affordable housing to protect the interests of the individual with behavioral health needs
- Assist with projects advancing the needs of the behavioral health community

### QUICK FACTS

- Homelessness in Lake County grew 36% between 2011-2014
- Costs \$172,000 to incarcerate someone for a year in the state of IL
- 20-25% of the US homeless population suffers from a form of severe mental illness, compared to only 6% of the general population
- Mental illness the 3rd leading cause of homelessness
- 15% of people with serious mental illness were homeless at least once in a one-year period; those afflicted with schizophrenia or bipolar disorder are particularly vulnerable.
- Half of the mentally ill homeless population in the US also suffer from substance abuse and dependence.
- Research has shown that supported housing programs (offering services such as mental health treatment, physical healthcare, education and employment opportunities, peer support, and social and financial management skills training) are effective for people with behavioral health.

### KEY STAKEHOLDERS



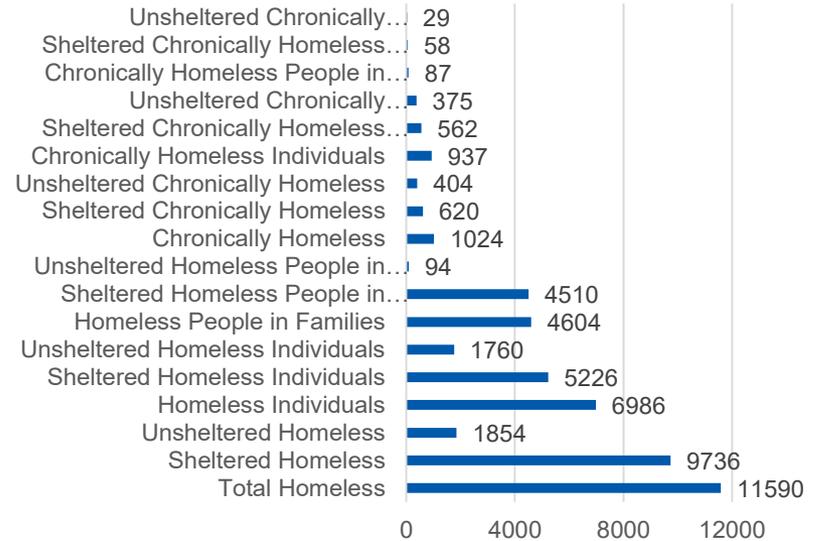
Community Organizations



Homelessness Groups

The below graph is provided to highlight the prevalence of housing needs across Illinois. Note that this is not specific to individuals with behavioral health needs.

### ILLINOIS HOMELESSNESS STATISTICS (2016)



# COMMUNITY ORGANIZATION PROCESS FLOW

**Process Flow:** Individuals are often referred to community organizations after discharge from a hospital, upon recommendation from law enforcement, or by other community organizations. Community organizations are critical in addressing some of the societal determinants of health and can offer services difficult to obtain elsewhere. In some cases, individuals seek out community organizations for services that can be provided by a bilingual service provider. Community organizations will collaborate well together to service a common client or individual with behavioral needs and will often refer individuals to one another in an effort to address the entire spectrum of needs.

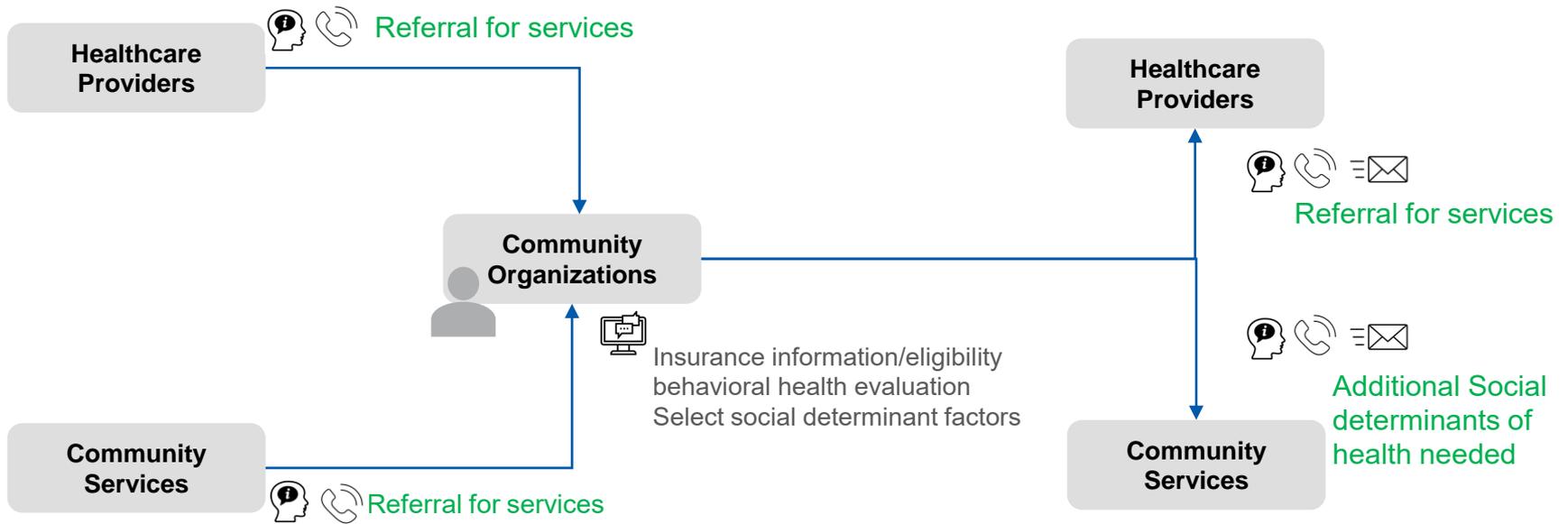
## Key Observations

### Functional:

- Electronic communications are limited which makes any transfer of data more time-consuming. Most of the information is transferred via phone or hard copies which creates room for losing data and manual error when transcribing information.
- Limited funding and higher priorities are cited as a major reason for the lack of a stronger technology infrastructure.
- Employee specialization, which makes select operational efficiencies possible, can be difficult in smaller community organizations, individuals need to assume many and varying responsibilities.

### Technology:

- Most of the organizations use Excel to capture information. Excel is often used where other programs fail to capture the data organizations want to capture. However, Excel, unlike more advanced programs, typically does not include the rules and restrictions required to standardize data entry, such as formatting and ensuring cells are completed, which presents significant data quality concerns. The benefits of using Excel include that it is a familiar tool across providers, and if an Excel file is shared, it can be easily adapted into new programs. Additionally, while standardization rules may not be in place, it does outline 1:1 ratios between cells which can help in identifying missing information.
- Housing organizations and select partners also use Service Point to track referrals between individuals and community care providers. Additionally, it tracks information regarding individuals who need housing, assignments, and move-ins. It also has some case management information, such as case notes, tracking services, outcomes, class attendance, and case manager assignments. Service Point is a single source of shared information and as such it provides a consolidated list of homelessness needs which assists in the coordination of housing efforts. Areas of opportunity with the program as provided by interviewees include report generation and additional fields so that it can capture more data points.



- Organizations vary in whether they set up an appointment or if the individual with the behavioral health need is responsible for setting up the appointment.
- Individuals are often referred to community providers for bilingual services, especially if the organization provides both healthcare and community services.
- Organizations each have their own intake form and assessment, which can include questions that screen individuals for behavioral health needs.
- Service Point is the most consistently used program across community organizations and enables greater data visibility across organizations.
- Community organizations may refer individuals to a different healthcare organization. While conversations may occur during an individual's transfer, unless there is a formal agreement signed, no electronic data is transferred between the two organizations so data retention is difficult.

**Legend**  
**Medium of Communication:**  
 = Participant Entry point   
 = Phone Call   
 = Electronic Communication   
 = Verbal communication   
 = Email   
 ABC = Data collected and stored   
 ABC = Data transferred

The following diagram outlines the strengths of the Community Organization sector as it pertains to data sharing, the benefits or “what’s in it for me” messaging, concurrent opportunities or initiatives that can complement a data sharing initiative, and the barriers perceived. As organizations move forward towards systemic data sharing, the below values of data sharing and the obstacles to sharing data will be analyzed further.

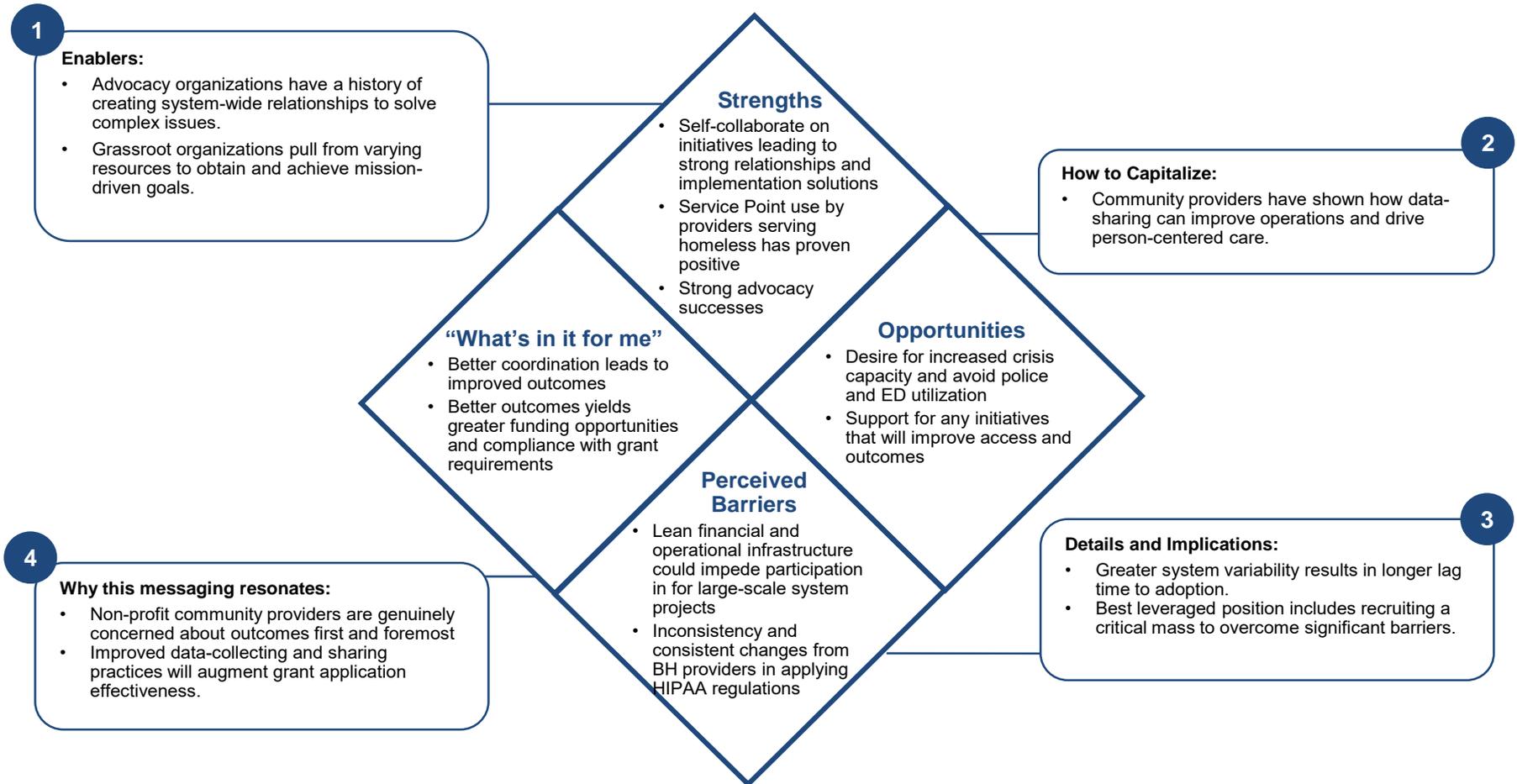
**“What is in it for me”:** Greater knowledge of needs and capacity can put less strain on lean resources.

- Improved data sharing can better position providers that have not seen patients before to understand the full scope of needs and other players involved in their care.
- Community members see the uninsured and underinsured and improved data can help quantify the needs of this population which can assist with grant applications.
- With improved data sharing monitoring patients’ progress and measuring health outcomes and success is easier.
- Improved data can help to identify opportunities for intervention and proactive outreach before events occur.

**Barriers:** Funding and resources were the most commonly reported barrier.

- Community organizations report being strapped for resources and running a lean operation. New practices for collecting, aggregating and analyzing data would come with an opportunity cost. Without robust technology, any related health information for an individual is often stored in text box form which can be difficult to extract.
- Community organizations noted that having a variety of electronic programs to manage the information they collect, but that those programs often do not speak with one another and are not capable of capturing all of the information that may be collected.
- Community organizations partner with a high volume of providers and other community organizations and report that information received from providers is inconsistent. When coordinating care on the societal and health needs of a patient, the community organizations stressed the operational demand of constantly adapting to the organization with which they are working.

# COMMUNITY ORGANIZATION SWOB



## Important Takeaways

- Community providers have overcome scarce resources by forming non-competitive alliances to leverage their respective strengths.
- Smaller infrastructures allow for quicker adaptations to changes and under-served needs in the community.
- A general lack of liquid capital prohibits large-scale investment in more robust data-management platforms.

## 3.2.3 CURRENT DATA SHARING TECHNOLOGY

### TECHNICAL OBSERVATIONS

Several themes surfaced during interviews when discussing technically specific to data sharing within each sector that can greatly impact each sectors' ability to share data in the future. In addition to the technology highlighted as a part of the process flows above, below is an analysis of the themes that surfaced:

#### HEALTHCARE ORGNAIZATIONS

- **Hospital EHR's focus on internal data sharing:** EHRs enable easier data sharing within the same hospital, but historical efforts driven by laws to treat mental health differently, have created environments within a hospital that use different technologies for mental and physical health. Some hospitals, like Vista, have more than one EHR, one for physical care and another for behavioral healthcare. Other hospitals, like NorthShore<sup>15</sup>, can separate select behavioral health data from physical health data within the same EHR and only allow access to the behavioral health data to select users. These organizations are making efforts to integrate their data as the healthcare industry trends to integrated physical and behavioral health.
- **Limited data sharing exists between hospitals:** Data sharing between hospitals is very limited outside the four walls of their organization. While there are some privacy concerns, technically, the EMR systems are all heterogeneous and require a means to share data between organizations. For instance, hospitals with EPIC and Cerner programs can not easily share electronic files with one another and therefore hospitals like Northwestern and Vista must use fax and phone to communicate.
  - **Hospitals agree HIE would be the best way to share data:** Several organizations mentioned past efforts to start a regional HIE (both Metro Chicago HIE & Illinois State HIE). Both efforts were unsuccessful but would have provided significant improvements for sharing data between the hospitals and other care providers. The HIE would allow hospitals and providers to push patient medical records to the HIE database (with necessary consents in place), and then allow the organizations needing specific patient records to pull those from the HIE database. The hospitals and health centers interviewed agreed that an HIE would still be the best way to share data.
  - **Direct Messaging between hospitals has provided mixed results:** The Lake County Health Department attempted to work with several local hospitals to implement direct messaging of patient medical records – with mixed results. Direct messaging requires the use of a HISP (Health Information Service Provider) and knowledge of the direct messaging address of the recipient to send secured data. The challenge of direct messaging is when a patient walks into a hospital, it may be difficult to ascertain the direct messaging address of the patient's primary care physician. As in the case of Advocate Condell and NorthShore, the burden of additional processing to load the patient's Lake County direct message address was one they were not willing to take. However, Vista was willing to come up with a manual workaround.
  - **Standard data sets need to be well defined to provide smooth interchange of data:** In either case, standard data sets (ADT, notes, vitals, labs, images, etc.) need to be well defined as well as the transport structure (HL7, C-CDA, FHIR) to and from the healthcare organizations in order to provide smooth interchange and use of healthcare data.

#### Case Study:

- **Thresholds:** Thresholds has built a data connection, using Orion HIE connectivity software, with several healthcare providers in Cook County, initially to obtain appointment times. Eventually, it will begin to collect additional patient EMR records. The work that Thresholds has started could be the launching pad of a data sharing/exchange implementation for Lake County.

# DATA SHARING TECHNICAL OBSERVATIONS

## JUSTICE SYSTEM

### **Oracle Enterprise Service Bus (ESB) is beneficial**

Within the court and judicial system, it is a benefit to have the Oracle Enterprise Service Bus (ESB) to exchange data between all of the systems (CRIMS, VisionJAIL, VisionRMS, SAMS, etc.) that have been connected to the ESB. The ESB allows the routing of messages, which contain data, to be exchanged between disparate computers, systems, and networks. An ESB can adapt to older technologies and works well for a business with legacy systems.

### **Other applications can be added to the Oracle Enterprise Service Bus (ESB)**

Given the existence of the Lake County ESB, it is possible to add other applications to the ESB to increase data sharing. Applications could include programs within the justice sector that are not currently connected, such as police CAD systems, or programs that are connected but do not share as much data as possible, like Caseload Explorer which receives updated court date information but could receive and send additional information. Both the sending and receiving applications would require adapters and programming to convert data into messages and vice-versa. This should be considered when digitizing current paper communications into electronic formats.

## COMMUNITY ORGANIZATIONS

### **Technology maturity**

Some community organizations are not as technology mature as their technology systems tended to be less robust and those services the programs were not as data and analytics oriented. As such, data is less standardized and across a large number of hosts which makes data sharing within and with community organizations more difficult. This challenge is common and has led similar organizations across the nation to partner together on back-office services to recognize some economies of scale.

## DATA STORAGE

Data sharing solutions employ many different kinds and combinations of infrastructure, architecture, and applications.

Regardless the specific technologies used, it is incumbent of the system architect and designer to ensure that all federal and state laws are followed and implemented within the application.

### Technology Architecture of Programs cited in Current Data Sharing Assessment Interviews

System	Technology Architecture
Service Point	Cloud Based
Epic	Client Server or Cloud Based
NextGen	Client Server or Cloud Based
Cerner	Client Server or Cloud Based
Athena	Client Server or Cloud Based
CaseLoad Explorer	Client Server or Cloud Based
CRIMS	Mainframe
Vision CAD	Client Server
Vision RMS	Client Server
Vision Jail	Client Server

## DATA STORAGE

The architecture or product chosen by an organization has implications as it pertains to sharing data, be it the process for making changes to the system, the connectivity of the system, or adaptivity of the system over time.

### Cloud-based

Cloud-based architectures allow access to information from any location which can help geographically diverse workforces or organizations that share data in more real-time fashion. Cloud-based programs are perceived as less secure and healthcare centers are particularly hesitant as a result. The evolution of cloud-based programming would suggest that it is easier to share information from a cloud than other programs.

Those organizations with cloud-based software may be more willing to engage in a sharing agreement given the existing technology capabilities as long as security and PII concerns are addressed.

### Client Server

Client servers can be located in a single geographical area which makes the viability of these programs susceptible to geographic risk. The operations of the organization, and any electronic sharing agreements with said organizations are dependent on that server continuing to function well. If there is a technical issue with the server, front-line workers have limited operability until resolved. Users hoping to access information remotely likely have to VPN into a program, but depending on the organization's protocols that VPN may provide limited access.

### Mainframe

Mainframe systems have the benefit of being custom built to meet an organization's needs. In many cases, the resources to quickly make an update to the program are in-house since there is less reliance on outside 3<sup>rd</sup> party vendors. Therefore, implementation costs and updates are a part of daily activities and maintenance. This responsiveness and flexibility however can come at a cost depending on the depth to which solutions address the root cause of an issue.

As seen in the previous process flow diagrams, where data is stored electronically, data sharing solutions have been and will continue to employ many different infrastructures, architectures, and applications.

Data sharing by nature requires the transmittal of data/information between two or more parties. That transmittal will occur over either a private or public network. A public network, by its nature, will require a minimum of an additional layer of security around the data – usually in the form of encryption of some sort. An encryption key is agreed upon in advance or sent along with the encoded data.

The servers which house the applications and databases, whether stored locally or in the “cloud,” are made secure by ensuring a firewall is installed between the public network or internet and the server.

Data can also be shared directly between two entities in many different ways. Email can be employed by encrypting the data before being sent or by sending via a secured email service. The downside is that often times email servers limit the size of data that can be shared. Another alternative is to set up a secured FTP (SFTP) site between two organizations. At times, it can be time-consuming to set up; however once set up, a high level of confidence exists regarding the security level for sharing data between two entities.

## 3.2.4 CURRENT DATA AVAILABILITY AND EXISTING PARTNERSHIPS

### INTRODUCTION

An understanding of the current data available and how those data points are aggregated or shared is critical to understanding starting points and opportunities for sharing data across the Lake County behavioral health community. In the below pages is the following:

- Data sharing hierarchy framework
- Existing data sharing partnerships within the Lake County behavioral health community
- The data available at a participant-level across organizations within each sector
- Data metric best practices and the data metrics available

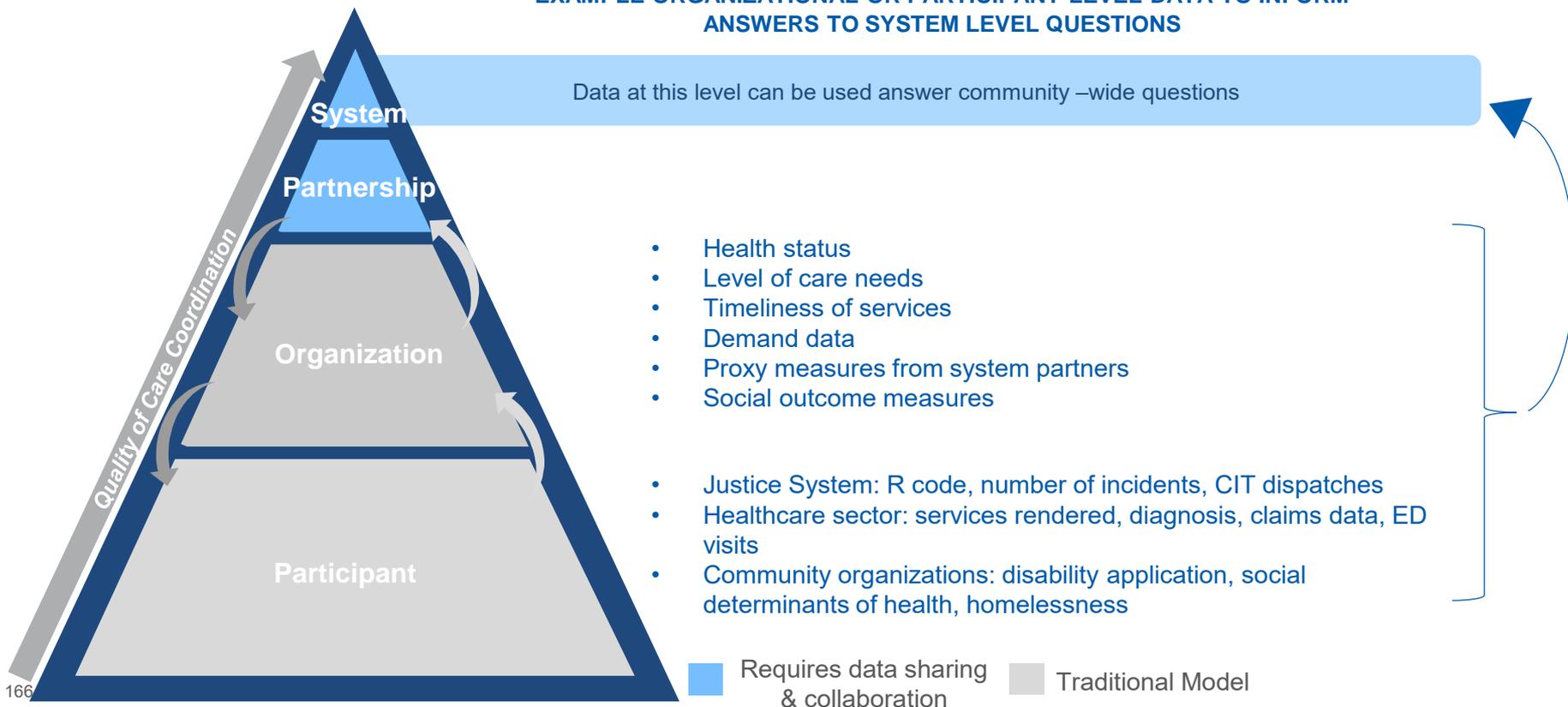
The following analysis is a summarized, consolidated view into the data available. A comprehensive list of the data points and data metrics including, whether or not they are available at the participant or aggregated level, can be found in *Appendix 7.10 Data Matrix – Extended List of Data / Measures*.

# DATA SHARING HIERARCHY

While data exists across the Lake County behavioral health community in many different programs, Lake County needs to share data across the entire system to answer the system-wide level questions identified in the visioning session and Coalition meetings. This hierarchy is organized from the bottom up with data having the ability to ascend the hierarchy to inform higher level data metrics, such as aggregated participant-level information per service provider or organizational level data. The most powerful set of data is at the top with participant-level information being shared across the county at the system level to enable system-level metrics.

The following pages highlight some of the data available across the Lake County behavioral health community as it relates to the below data sharing hierarchy.

## EXAMPLE ORGANIZATIONAL OR PARTICIPANT-LEVEL DATA TO INFORM ANSWERS TO SYSTEM LEVEL QUESTIONS



## EXISTING PARTNERSHIPS

Formal and informal data sharing partnerships exist within the Lake County behavioral health community, although there is no system-wide data sharing for the Lake County behavioral health community. Formal or more structured partnerships include programs developed to collaborate on care and address the needs of those who have high utilization of services. Below are several examples of these formal partnerships. Informal data partnerships exist to coordinate care, as illustrated in the Sector process flows provided in section 3.2.2. *Sector Analysis from Interviews*. An example of an informal data sharing partnership includes police verbally providing information to hospital staff when admitting a behavioral health individual.

The data that is shared at the partnership level is possible through formal relationships and project-style collaborations between a few organizations. These data sharing partnerships are largely grant driven, and as a result, the information shared and results are as of a particular time and for a limited duration of time. However, select on-going data sharing initiatives within Lake County that surfaced through research and interviews include:

**Lake County Health Department and Vista-** Lake County provides Vista with a list of their covered entities and Vista sends an Admit, Discharge, Transfer (ADT) message for that patient.

**Northwestern and Erie Family Health Centers** have a long history of partnering together on initiatives to help individuals receive the care they need at the appropriate time and in the appropriate setting. Erie Family Health recognizes the power of data through their own HIE systems.

**Service Point** is used by several community organizations to share data, particularly on homelessness. This is the only example of cross-sector data sharing that was discovered during the Current Data Sharing Assessment process

**Mental Health Collaborative** identifies individuals that could benefit from receiving all four of the partners' services and meets to discuss care plans on behalf of those individuals.

**Data-Driven Justice Workshop:** Commitment from the justice system to coordinate and partner with entities on the intercept model.

**Alliance for Human Services:** cooperation of diverse service providers dedicated to providing outcome-driven programs and services to ensure healthy and productive families and communities.

**Live Well Lake County:** population health minded organizations designed to guide the community health assessment process, prioritize community issues, and collaborate with one another and with stakeholders outside of the committee to take action and improve the overall health and well-being of residents in Lake County.

### Additional Informal Relationships:

- Behavioral health organizations partner with schools to improve student's health if made aware of a student need verbally by the school.
- Hospitals will reach out to community organizations as need be upon a patient's discharge and/or to provide follow-up services or services in a more appropriate setting. This care coordination largely occurs over the phone.

## HEALTHCARE ORGANIZATIONS DATA AVAILABILITY OBSERVATIONS

The chart on the following page depicts the data available across select organizations and programs within the healthcare sector. The chart was compiled using information shared during interviews as well as data points known to be a common feature in EMR and healthcare supporting technologies. Observations pertaining to the collection and sharing of this data include:

**The healthcare organizations' EMRs contain patient identifying attributes, demographics, as well as various physical healthcare details and attributes.** Detailed data elements were not provided by each hospital but there was a general understanding of what data exists.

**The amount of behavioral health data collected by the healthcare organizations is unknown.** It is unknown how much behavioral health-related data is collected for each EMR, except in cases where the EMR is focused on the behavioral healthcare provided and data is collected, such as Athena.

**Data sharing in Lake County is very limited.** Although each hospital has rich patient data within their respective EMRs, electronic sharing of that data is very limited within Lake County. If the information is shared, it is generally shared by either faxing documents or paper copies transferred with the patient and the information provided, may not be the full patient history, but only the information relevant to a specific care event or incident.

**Epic EMR has it's own data sharing network/hub with other healthcare organizations using Epic.** Those hospitals (NorthShore and Northwestern) who have or will have Epic as an EMR have stated that they share electronic medical records with other facilities that have Epic thru Epic private network/hub.

**Thresholds is working with HIE software.** Thresholds built a data connection, using Orion HIE connectivity software, with several healthcare providers in Cook County, initially to obtain appointment times. Eventually, it will begin to collect additional patient EMR records. Thresholds is very interested in working with facilities in Lake County.

# HEALTHCARE SYSTEM DATA AVAILABLE

## PARTICIPANT-LEVEL DATA

Detailed data elements were not obtained for hospital EMR systems as known categories of data exist across systems. It is unknown how much behavioral health data is collected for each EMR, except in cases where the sole purpose of the record is to capture BH/MH data, such as Athena. In each case, the organizations contracting with the vendor owns the data, but the availability to pull data may require coordination with the vendor system if the report and filters are not already in place.

	NextGen LCHD	Epic NS, NW	Cerner Condell Vista	Athena NS	Centricity Erie Family	SmartCare EMR Thresholds
<b>Name / ID</b>	Y	Y	Y	Y	Y	Y
<b>Demographics</b>	Y	Y	Y	Y	Y	Y
<b>Primary Care Physician</b>	Y	Y	Y	Y	Y	Y
<b>Diagnosis</b>	Y	Y	Y	Y	Y	Y
<b>Medications</b>	Y	Y	Y	Y	Y	Y
<b>Labs</b>	Y	Y	Y	Y	Y	U
<b>Doctor's Notes</b>	Y	Y	Y	Y	Y	U
<b>Admit/Discharge/Transfer</b>	Y	Y	Y	Y	Y	U
<b>Claims</b>	Y	Y	Y	Y	Y	Y
<b>ER Visits</b>	Y	Y	Y	U	U	U
<b>Inpatient Stays</b>	Y	Y	Y	Y	U	U
<b>Assessment / Evaluation</b>	Y	Y	Y	Y	Y	Y
<b>BH Care Provider</b>	Y	U	U	Y	Y	Y
<b>BH Related Data</b>	Y	U	Y	Y	Y	Y
<b>Appointment Times</b>	U	U	U	U	U	Y

### Legend:

**Y** = Data Available

**U** = Unknown

**N/A** = Not Applicable

\*Based upon information provided during interviews

## JUSTICE SYSTEM DATA AVAILABILITY OBSERVATIONS

The chart on the following page describes the information that is available within the Justice System on behalf of behavioral health individuals. The Justice System has not historically always captured this information and therefore a relatively lower volume of data is available.

**Behavioral health data is heterogenous and inconsistent.** The availability of behavioral health-related data is heterogeneous across the justice system and can vary greatly.

**CAD has very limited, usable behavioral health data.** As 911/dispatch receive calls, they can identify that the call is behavioral health-related and record the fact it is within the CAD notes. However, CAD notes are difficult to query and report.

**CIT forms have behavioral health data captured however it is not in electronic format.** Very minimal behavioral health data exists within law enforcement per its focus on justice, with the exception of the CIT assessment forms. The CIT forms currently remain on paper and are not captured electronically. As the CIT program becomes more robust, greater information about behavioral health at the time of an incident will likely become available.

**Citations have the Illinois Uniform Crime Reporting (IUCR) codes (R-code) as the only piece of behavioral health related data.** The citation currently only has the R-code, which indicates the offense committed. There is an R-code for a behavioral health-related incident; however, if a more violent offense is involved, its R-code has priority and is recorded.

**CRIMS court system has minimal behavioral health data.** The court system has very little behavioral health –related data with the exception of the Sub Court Type which can be assigned to the Mental Health Specialty Court. Any information related to the psychology or behavioral health of an individual is stored in paper format.

**Probation systems have more behavioral health data.** Probation, with the use of both CaseLoad Explorer and Service Point, has more behavioral health data to coordinate services and follow up on routine appointments. However, probation can not share data without a court order which presents a significant barrier for sharing information to coordinate care.

On the following page is a chart depicting the data available within the Justice System. Very minimal BH/MH data exists within law enforcement per its focus on justice, except for CIT forms. As the CIT program becomes more robust, greater information about behavioral health at the time of an incident may become available. More BH/MH data exists with probation as they coordinate services and have routine appointments.

# JUSTICE SYSTEM DATA AVAILABLE

## PARTICIPANT-LEVEL DATA

	Dispatch	Police / Sherriff			Jail			Court	Probation	
	Vision CAD	RMS	Citation	CIT Form	Vision Jail	Care EMR	Digipen Bond	CRIMS	CaseLoad Explorer	Service Point
Name / ID	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Demographics	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
R-Code (BH related issue?)	U	Y	Y	N/A	U	N/A	N/A	N/A	N/A	N/A
Assessment / Evaluation	N/A	U	U	Y	U	Y	N/A	N/A	Y	Y
Violence History	U	N/A	U	Y	U	U	Y	U	Y	Y
Suicide Risk	U	N/A	N/A	Y	U	U	Y	U	Y	Y
Homelessness	U	N/A	U	Y	N/A	N/A	N/A	Y	U	Y
On Probation	U	N/A	U	Y	U	N/A	Y	Y	Y	Y
On Parole	U	N/A	U	Y	U	N/A	Y	Y	Y	Y
Substance User	N/A	N/A	N/A	Y	N/A	Y	N/A	N/A	Y	Y
Received Treatment for Substance Use	N/A	N/A	N/A	Y	N/A	U	N/A	N/A	Y	Y
PCP	N/A	N/A	N/A	Y	N/A	U	N/A	N/A	U	Y
Last Medical Exam	N/A	N/A	N/A	Y	N/A	U	N/A	N/A	U	Y
Medications	N/A	N/A	N/A	Y	N/A	Y	N/A	N/A	U	Y
Specialty Court Program	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	Y	N/A
Therapy Sessions Status	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	U	U
Applied for Disability	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	Y

\*Based upon information provided during interviews

**Legend:** Y = Data Available U = Unknown N/A = Not Applicable

## COMMUNITY SYSTEM DATA AVAILABILITY OBSERVATIONS

Similar to the justice program, community organizations do not capture the volume of data that healthcare service providers currently record. However, where operational processes allow, community organizations try to assess the behavioral health need. Therefore, while fields may be available, they may not always be populated for individuals seeking and utilizing community services.

**There is limited data/systems in the community service providers.** There was very limited data available and shared in the community systems, with only a few exceptions.

**The application Service Point is used by the community.** Service Point is predominately used for tracking and placing individuals who are or were homeless. It is also used for making referrals between some facilities.

- Service Point contains more standardized information as a result of having multiple and various different users for select data points – it serves as a data hub for those entities who use that software.
- Service Point is currently under review for expanded use and the corresponding compliance for that additional use.
- Service Point has some/limited data integration capabilities but would need to be further explored.

# COMMUNITY SYSTEM DATA AVAILABILITY ANALYSIS

## PARTICIPANT-LEVEL DATA

There was very limited data available in the community systems, with a few exceptions. Detailed data elements, if available, were not shared or listed at length; however, some elements are known to be collected as they are required for data sharing (i.e. demographics).

**Legend:**

- Y = Data Available
- U = Unknown
- N/A = Not Applicable

	Service Point PADS	SmartCare EMR Thresholds	Excel LCRDC
Name / ID	Y	Y	Y
Demographics	Y	Y	Y
Homelessness	Y	Y	Y
Applied for Disability	Y	Y	N/A
Substance User	Y	Y	N/A
Received Treatment for Substance Use	Y	Y	N/A
Violence History	Y	Y	N/A
PCP	Y	Y	N/A
Last Medical Exam	Y	Y	N/A
Medications	Y	Y	N/A
Appointment Times	U	Y	N/A
Family member with disability?	N/A	N/A	X

\*Based upon information provided during interviews

# DATA SHARING OF AGGREGATED METRICS

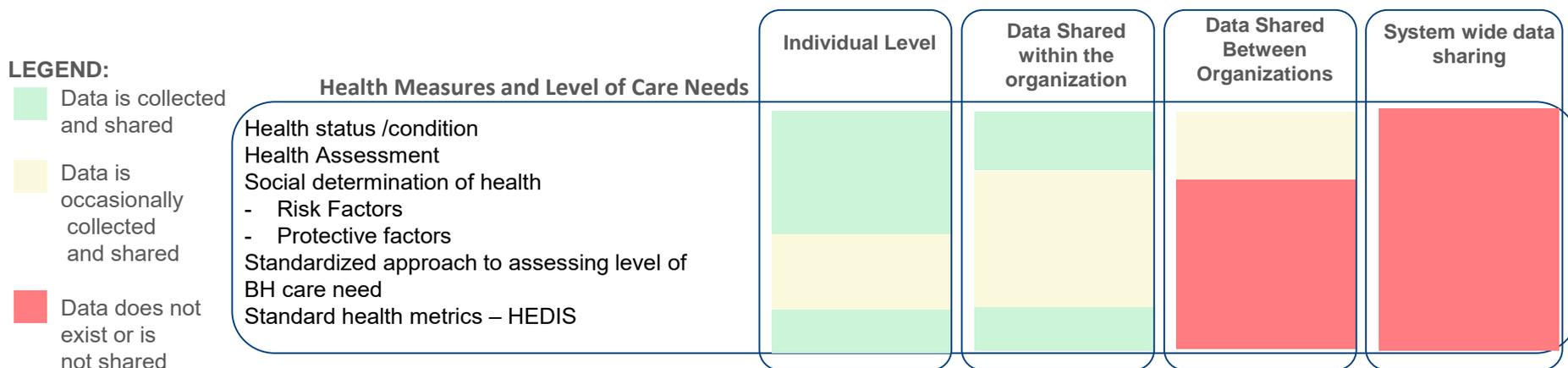
## AGGREGATED ORGANIZATIONAL LEVEL DATA

Systems with data sharing capabilities will look to physical, behavioral, and societal measurements of health to determine the needs of individuals. Below are the best practice measurements used by other communities to determine behavioral health need.

These measurements are made possible by standardized data collection and monitoring of individuals' progress across organizations. Within Lake County's behavioral health community, some of these measurements are measured by organizations internally, and of those that are measured, select results are shared with other organizations. When shared or measured at a systematic level, this data is typically aggregated by a central organization or repository, which in some communities is a Crisis Call Command Center.

Organizations that share data need to have standards for the data point definitions to achieve systemic data sharing. This requires determining how providers differentiate their behavioral health population, which may require the addition of a data field or marker within their technology programs.

Below is a heat map to describe where best practice aggregated data metrics are shared across Lake County's behavioral health community.



### STRENGTH

Data collected at the organizational level is helpful to a clinician at the point of service.

# DATA SHARING OF AGGREGATED METRICS

## AGGREGATED ORGNAIZATIONAL LEVEL DATA

**LEGEND:**

- Data is collected and shared
- Data is occasionally collected and shared
- Data does not exist or is not shared

Behavioral Health System Process Measures	Individual Level	Data Shared within the organization	Data Shared Between Organizations	System wide data sharing
<i>Urgent Services</i>				
Crisis line – Average Speed of Answer				
Mobile response time to the community				
Mobile response time to police				
Crisis Stabilization – <b>Low to Moderate Crisis</b>				
Crisis Stabilization – <b>Acute Crisis</b>				
Crisis – Urgent Care drop off timeliness for police				
Timeliness of access to inpatient care – length of time waiting in ED				
<i>Routine Services</i>				
Appointment Standards % within a designated timeframe				
- Psychiatric care – medication assessment				
- Counseling Services				
- Support Services				

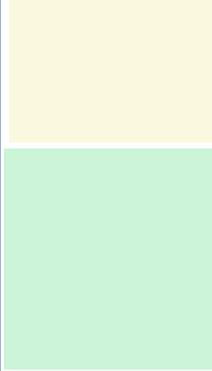
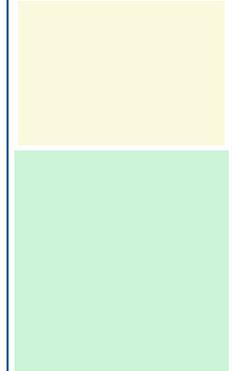
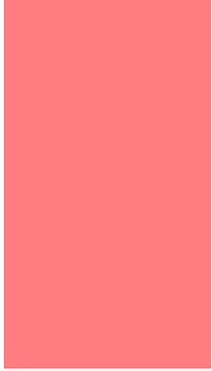
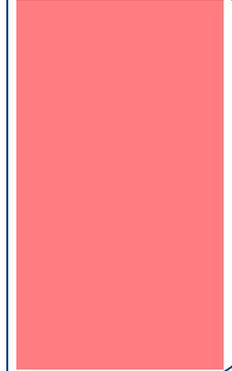
**OPPORTUNITIES**

- There are virtually no measures shared between organizations or at a system-wide level to enable an aggregated analysis for making data-driven, systematic decisions about service capacity needs.
- Although the state requires a standardized approach to identifying "Level of Care", this information is not aggregated for Lake County as a whole.

# DATA SHARING OF AGGREGATED METRICS

## AGGREGATED ORGNAIZATIONAL LEVEL DATA

- LEGEND:**
- Data is collected and shared
  - Data is occasionally collected and shared
  - Data does not exist or is not shared

	Individual Level	Data Shared within the organization	Data Shared Between Organizations	System wide data sharing
<b>Demand Data – Proxy Measures from System Partners</b> Police dispatched – BH Need identified Jail – Prevalence of BH conditions Use of high level services - emergency department for BH Use of high level services - Repeat utilization – emergency department Use of high level services - Inpatient Psychiatric Prevalence of BH condition in emergency department				

### OPPORTUNITIES

- Proxy measures from law enforcement indicating the need for behavioral health intervention vary across departments if it is collected at all. Data collection would need to be standardized to be used at the aggregate level to inform capacity needs.
- Emergency departments are collecting utilization data for individuals with behavioral health. However, the data is not aggregated to truly understand the extent of overutilization or duplication across EDs. There is no data-driven information to inform overall system capacity needs for acute behavioral health needs.

# DATA SHARING OF AGGREGATED METRICS

## AGGREGATED ORGNAIZATIONAL LEVEL DATA

**LEGEND:**

- Data is collected and shared
- Data is occasionally collected and shared
- Data does not exist or is not shared

	Individual Level	Data Shared within the organization	Data Shared Between Organizations	System wide data sharing
<p><b>Social Outcome Measures</b></p> <ul style="list-style-type: none"> <li>#/ % with past drug/alcohol use history, now no use</li> <li>#/% Are not homeless</li> <li>%#/ Are employed</li> <li>#/% Attend school</li> <li>#/% No recent criminal justice system involvement</li> <li>% successful completion of Specialty MH Court program</li> <li>% successful completion of probation – referred for BH services</li> </ul>		<div style="background-color: #90EE90; width: 100%; height: 100%;"></div>		
<p><b>Homelessness Measures</b></p> <ul style="list-style-type: none"> <li>Need for housing services</li> <li>Standardized approach to measuring needs</li> </ul>				

**STRENGTH**

- Homeless providers have developed standardized ways to assess housing need by priority factors, share data across providers, and aggregate the data for use in planning.

**Data Sharing Observations:**

- Lake County does not currently have any systemic data sets to enable systemic data-driven decision making, with the exception of homelessness, which leverages Service Point as their single HMIS system.
- Lake County is missing the data at the system and, often, the partnership level that other communities that measure behavioral health needs use to assess availability and progress across a community.
- In some cases, the data is available in an aggregated fashion at the organizational level, but the calculation of that data across organizations is different. In some instances, the metrics are missing because the data point required for calculation is not collected.

## ORGANIZATIONAL DATA AVAILABILITY OPPORTUNITIES

The participant-level data collected by each organization varied as did the aggregated data metrics that each organization shared if any. Looking at commonly used and missing data sets within the community can help identify early starting points for a data sharing program or supporting processes required to access to beneficial datasets respectively.

### Available data sets that can enable data sharing:

- Within the justice system there is one Jail, one probation and one Court system therefore their records of individuals and the data filters or analysis capture the full jail, probation, and court demands and can serve as the sole source for the type of data is stores.
- Many organizations need to fill out similar forms, such as the paper work to apply to be a Medicaid recipient. This information can be leveraged across organizations to have a system level data set. For example, IL Rule 132: Title 59: Mental Health, Chapter IV: Department of Human Services, Part 132, Medicaid Community Mental Health Services Program Outlines requirements for participation in Illinois Medicaid program including provider accreditation and documentation required. Regulations reference compliance with national privacy regulations as well as the Illinois 740- Mental Health Confidentiality rules. Organizations have employed a variety of approaches for meeting the documentation requirements, as evidenced by the variability in intake forms, and this information can serve as a starting point for like data points for a future data sharing initiative in Lake County.
- Homelessness has a consistent way to capture information due to its central location for documentation and state mandated HUD measures.

### Missing Data sets that can enable systemic data sharing are below:

- Claims data from MCOs or hospitals
- Eligibility files- MCO and Medicaid would provide insight into who has Medicaid as well as the date ranges and potentially the services they are eligible for. This information is typically available from the insurance company, but not hospitals.
- Crisis information, such as individuals presenting crisis and diversion statistics, is largely uncaptured due to the lack of awareness around crisis service availability and the difficulty of accessing the crisis information.
- Aggregated, cross-jurisdiction police information for a more accurate estimate encounters and potential causality.
  - Metadata from electronic systems
- Universal behavioral health forms (intake, consent to release information, health information data transfer, assessments)
- Standard list of agreed-upon best practices/data metrics against which Lake County organizations can compare their data

## 3.2.5 BARRIERS TO DATA SHARING

### INTRODUCTION

The following section conveys the barriers to data sharing cited by interviewees. The information provided was sorted across-sectors. Barriers were then quantified into three groupings of high, medium, and low based on the emphasis with which a barrier was communicated and the frequency with which it was mentioned within and across interviews within the same sector. In some cases, the perception of a barrier exceeded or underestimated the real magnitude of that barrier.

The ability for organizations to get started with data sharing is influenced by these challenges which can include operational, legal, and technical barriers to data sharing.

The following pages describe:

- Barriers including the type of barrier, the perceived magnitude of the barriers;
- Background and contextual information about barriers;
- Perceived magnitude of barriers; and
- The largest barriers to overcome by organizations and system-wide.

# BARRIERS

Below are the barriers that were cited during interviews and these barriers are real challenges for organizations to participate in a data sharing model. An indication of the emphasis with which the barriers were communicated is also provided to indicate the magnitude of that barrier as it is perceived by organizations. North Highland evaluated these magnitudes in comparison to the activities required to overcome the barriers and in the larger context of the behavioral healthcare trends to assess whether the perceived magnitude of the barrier as expressed matched the true nature of it.

BARRIERS*	HEALTHCARE	JUSTICE	COMMUNITY
Internal Bureaucracy & Red Tape	M	H	
Legal regulations to storing new data		M	
Nowhere to store behavioral health information in existing technology programs	M	M	H
Legal Regulations to begin sharing data	H ✓	M	L
Constant changes to policies and regulations	H H		H H
Varying interpretations of the law	H	H	H
Navigating consent forms and determining validity across organizations	M M		
Privacy and Security System Compliance	H H H	M M M	
Security Breach & Leaked Information	H	H	H
Disparate Technology Systems within and across organizations	M	M	H ✓
Changing technology at the state Level	L L		M M ✓
Cost of technology system/automation required to participate	M M		H H ✓
Standardization of encryption requirements across participants	L L L	L L L	L L L
Report Generation	H H	H H	H H

Barrier type		Barrier Magnitude	
◆	Legal	■	High
■	Technical	■	Medium
●	Operational	■	Low
✓	Perceived difference in the strength of the barrier		

## BARRIERS CONT.

BARRIERS*	HEALTHCARE	JUSTICE	COMMUNITY
Need to train on new practices for documenting new data	L	L	L
Unclear of role in sharing data			L
Data Governance (ownership, responsibilities, and maintenance)	H	H	H
FTE needs	L	L	H
Constant Change makes organizations leery of committing	M		M
Coming to agreement on the standardization of data	H	H	H
Education and required technology skillsets to operate in a data sharing agreement			L

The cited barriers fell into three themes as it relates to data sharing: the legal concerns and ramifications of data sharing, current technical or program limitations to data collection and communication, and operational resource planning for the establishment and maintenance of a data sharing program.

Barrier type		Barrier Magnitude	
◆	Legal	■	High
■	Technical	■	Medium
●	Operational	■	Low
		✓	Perceived difference in the strength of the barrier

## BARRIERS BACKGROUND AND CONTEXTUAL INFORMATION

Several of the barriers to data sharing that were cited have a larger context as it relates to data sharing, and understanding that background information helps to determine the real magnitude of that barrier and future mitigation strategies to overcome said barriers.

### OPERATIONAL

#### Healthcare Providers

While hospitals have the most robust data sets, not all measurements are captured specifically for the behavioral health population. Furthermore, capturing the same data points across departments may not be available within the front end programming, such as time of transfer from ED to Inpatient or wait time in the ED, and as a result, will require metadata from time stamps that involve additional processes. Definitions of what constitutes behavioral health patients also need to be agreed upon across service providers to know the population of patients to analyze and submit information on behalf of, as opposed to all patient seen by the provider. Service providers will likely need to agree to a list of ICD 10 codes listed in patients' EMRs and establish the corresponding filters with calculating data.

#### Justice System

New fields would need to be added across organizations to 1) capture data in unique fields (as opposed to general text boxes) or 2) begin collecting information as the system has not traditionally captured this data. Such data points can include a standardized list of drop off locations and diagnoses and date ranges for those diagnoses.

#### Community organization

Employees at community organizations “wear many hats” and these organizations do not typically have a dedicated data analyst or systems team. Therefore, community organizations may need to evaluate the additional workload of programmatic data sharing and consider the benefits of shared resources to alleviate stress on an already-cross-trained workforce.

### LEGAL

#### Healthcare Providers:

HIPAA, 42 CFR, and 740 ILCS 110 are the primary concerns expressed for why organizations will not share information. Across the US, entities interpret HIPAA in various ways, and that interpretation can be influenced by state law, which can take precedence over federal law if it is more strict, as is the case with 740 ILCS 110. 42 CFR is a strict federal rule and programs that serve individuals covered by 42 CFR often institute a consent to release of information whereby the individual acknowledges data sharing on their behalf. Lack of operational ability to meet compliance needs often prevents data sharing between organizations and the fear and risk of a data breach has healthcare providers worried about the security of new programs.

#### Justice System:

Some data within the justice system is available publicly and it is for this reason that many care coordination efforts start with justice-related initiatives. While documentation concerning the behavioral health of an individual is assessed within the courts and shared with probation and the jails as need be, that information is not currently shared outside of the court system without court orders. These legal barriers to data sharing are time-consuming, and prevent or limit coordination of care.

# BARRIERS

## BACKGROUND AND CONTEXTUAL INFORMATION

### Community Organizations

Community organizations can face legal obstacles in sharing data from multiple sectors depending on the services provided which can influence operational practices and the type of data that can be shared. For instance, homeless organizations can share housing information but have different protocols for sharing behavioral health information that may be collected on an intake form.

### TECHNICAL

#### Healthcare Providers

Depending on the internal design and privacy policies, the individuals responsible for data aggregation or submitting patient data may need additional access rights. Hospitals have robust technology systems as EMR programs are designed specifically for the capture of a high volume of healthcare data. Because extracting information may require builds that are outside of the normal activities for the vendor, such as Epic or Cerner, the hospital may not have as much control to make changes as compared to a homegrown system. For instance, both Epic and Cerner have their own patient medical record formats. To submit that information into a central repository, it may require both organizations to build a translator file to put its profiles into a standard form, or unique field specific to a particular client. Some behavioral health providers collect similar data to the information stored in robust EMR systems, but do not have EMRs, and thus, store this information in various desktop applications. Extracting, standardizing and sharing this data may require additional technology applications and/or processes that will work to cleanse and improve data quality before sharing it with others.

#### Justice System

Mainframe operated programs, such as the CRIMS system used by the Lake County justice system, are often developed in-house. These programs are prone to having legacy solutions that address targeted issues as opposed to consistent program releases found in vendor-built solutions. Knowledge of the programs inner workings can often be dependent on a single person or employee who has been with the organization for a long time. If the product was built on a program that is no longer supported by the vendor, then the ability to build new fields or make changes in the program is limited and can present a challenge to creating connections for the purposes of data sharing. The Lake County justice system will be replacing their existing CRIMS program. An evaluation of the data sharing capabilities, including the architecture, interoperability, any behavioral health related data fields, change request process, and reporting functionality should be conducted in relation to this project during the vendor selection process.

#### Community Organizations

Some data collection may be outside of the core competency of the organization, so while it may be available for some participants that organization serves, ensuring data points exist for all may be difficult. Additionally, getting fields added within programs that are not built to support a different data type could pose challenges for the vendor. It is in part for this reason that community behavioral health providers are consolidating back-end services and using services such as ServicePoint to share data.

## BARRIERS

### PERCEIVED MAGNITUDE OF BARRIERS

As with any large-scale project involving cross-system stakeholders, there will be barriers to overcome. Further, its likely participants in cross-system collaboration efforts will have differing perceptions and experiences about the barriers that have to be overcome to move forward in a meaningful way. The following are examples of some of the barriers that were cited by some stakeholders as being significant to overcome.

- **Legal Regulations to begin sharing data** – Interviewees had varying interpretations of legal requirements with some saying the legal requirements were not able to be overcome. This is not the case as if the right efforts are made to establish agreements between organizations or across systems, these legal barriers are less insurmountable and greater data sharing opportunities can be recognized within the Lake County behavioral health community. More information on the factors contributing to this variability are available in section 3.2.6 *Legal Considerations to Data Sharing*.
- **Disparate Technology Systems within and across organizations** – Some interviewees conveyed that it will be almost impossible to share data across systems given that the programs used throughout the varying sectors were so different (disparate). While disparate systems make the solution more complex, it does not mean that a solution is impossible. Depending on the design of the technology considered for the Lake County data sharing initiative, there are many ways to address the differences in systems, and coding can make the sharing of data across system easier. All of these options will be considered and information provided to applicable stakeholders as the needs arise moving forward.
- **Cost of technology system/automation required to participate** – Interviewees would sometimes focus on a Health Information Exchange (HIE) solution when discussing data sharing mechanisms. Some interviewees would state that data cannot be shared as HIEs are too costly and too much effort to implement. Other solutions in addition to HIEs can enable greater data sharing and there should be continued education, which includes the associated costs, on these solutions to lower the perceived magnitude of this barrier. HIEs should be kept in mind as a potential for an extended long-term view of possibilities as these solutions come about in the future for Illinois.
- **Changing technology at the state level** – Changing data submission requirements to the state was conveyed during interviews as a frustration and negatively impacting providers from keeping pace with state requirements and local initiatives simultaneously. The need to constantly adapt requires resources and as such devoting resources to a data sharing initiative was cited as difficult. When identifying data to prioritize for the Lake County data sharing initiative, the required state data submissions must be part of the considerations to explore to lower the perceived duplicative work. Efforts to stress the operational efficiencies with data sharing, such as less time to coordinate care, should also be emphasized.

# BARRIERS

## LARGEST BARRIERS TO OVERCOME BY INDIVIDUAL ORGANIZATIONS

In addition to the barriers above, it is important to note that all barriers cited do exist for organizations, and for some in particular the reality of those barriers and overcoming them will be critical to the success of the data sharing project. Below are the barriers that North Highland believes are the largest barriers for organizations to overcome to participate in a data sharing initiative.

- **Legal Barriers:** The legal barriers are real and will be difficult to overcome but not impossible. More information on the specific legal barriers can be found in the following section *3.2.6 Legal Considerations for Data Sharing*.
- **Data Governance:** Many of the issues cited deal with data governance, including standardizing data across systems, data ownership, and change requests for storing data. The importance of data governance should not be underestimated in any data sharing initiative as it is nearly impossible to have high quality usable data with which to make decisions without the proper data governance. Data Governance can require significant upfront work while establishing a data sharing model, however this effort can help make future operations more smooth.
- **Report Generation:** This was frequently cited and is a high barrier for organizations to sharing aggregate level data and below are the common themes related to report generation expressed by interviewees. While this barrier may be easily overcome for some organizations, it was universally communicated across interviews which makes the volume of changes needed larger:
  - Changing the output of a report requires a vendor build in the case of larger, shared programs like Epic, Cerner and Service Point
  - The users of the report do not have the authority to make changes and would need to work internally to have that done which can take time
  - The report can only be run as of a certain date, such as month end or quarter end, so the information can be out of date and less useful
  - Type of report or calculation is not available in the current technology system to enable sharing data. It needs to be manually calculated and then shared via email if it is shared.
- **Funding:** Organizations expressed concern as to the funding needed to participate and maintain a data sharing model, especially in light of the Illinois funding issues. This is a real concern and will be dependent on the model chosen by the Lake County behavioral health community. There are low tech, low cost solutions for data sharing as well as costly, bidirectional technical solutions. The Lake County community will need to research available options and balance the value of each solution with the cost and available funding in order to establish and maintain a data sharing initiative. This may require agreement on prioritized functionalities and compromise between participating organizations.

# BARRIERS

## LARGEST BARRIERS TO OVERCOME BY INDIVIDUAL ORGANIZATIONS

There were several barriers related to data sharing that were observed during interviews that were not shared explicitly but that exist for organizations within the Lake County behavioral health community.

- **Resource constraints** – While not explicitly communicated, community organizations in their current operating models can struggle to maintain operability with the constant reimbursement and funding changes and potentially higher ratio of uninsured or underinsured individuals to private pay participants. Interviewees implied that the need for their services is increasing, but their ability to grow is handicapped by funding uncertainty.
- **Human resources** – Many organizations are strapped for resources and as healthcare organizations continue to meet Triple Aim\* objectives, costs are continually scrutinized. Resources were expressed as being cross-trained as employees already ‘wear many hats’ and take on a variety of responsibilities outside of their standard job description. Organizations that are either strapped for resources and cannot train a current employee on the responsibilities for participating, such as the process to aggregate data, may benefit from shared resources with other organizations in the same situation. Continued education on practices that have helped similar organizations be efficient and the operational benefits of data sharing can help ensure that the right structure is in place to support operations.
- **Impact of Past Unsuccessful Efforts** – Organization’s stories of past unsuccessful attempts (e.g. implementing statewide HIE) led to doubt for success of future efforts. The healthcare landscape is constantly changing and being influenced by outside factors, as evidenced in the national trends research, and the current conditions can be different than the context within which past initiatives were conducted. Applicable lessons learned from past initiatives should be incorporated, but there needs to be an understanding of current conditions that have changed from the past.

\*Triple Aim refers to the goals of improving the patient experience and the health of populations while reducing the cost of care. The goals of the Triple Aim are to 1) Improve the experience of care, 2) Improve the health of populations, and 3) Reduce the per capita cost of healthcare.

# BARRIERS

## LARGEST BARRIERS TO OVERCOME SYSTEM-WIDE

In addition to organizations, the Lake County behavioral health community as a whole will face its own barriers and challenges establishing a system-wide network composed of multiple organizations. Below are the barriers that North Highland believes are the largest barriers to overcome system-wide.

- **Conflicting Priorities** – Organizations’ internal projects may be prioritized over an external data sharing initiative and therefore dedicating the resources to participate in a data sharing program will require organizations’ leadership to see a real value in the benefits of data sharing throughout the duration of the project. There may be factors that impact an organization’s ability to devote resources that do not apply to the Lake County behavioral health community as a whole (i.e. a merger, internal technology upgrades). As such, the Lake County health behavioral health community will need to constantly reinforce the benefits of participating in a data sharing model and the community will need to persevere through the change and adapt to new relationships to maintain a data sharing model.
- **No single owner of large data set** - There is no single MCO or single source of all claims data within the Lake County behavioral health community. Claims data can be incredibly powerful in providing answers to questions that require knowing unique users, such as participant tracking across providers and outcome metrics. Efforts will need to be made to collect claims data.
- **Trust between similar service providers** – Organizations within the Lake County behavioral health community have been prototyping and launching different programs to engage and improve behavioral health and are very passionate about their work. Organizations appeared fearful of sharing data because of not knowing how that data would be used by competitors. North Highland also observed organizations’ hesitancy for sharing data as it could increase competition in a market with tight margins and funding uncertainty. If data moves at the speed of trust, this will be a significant barrier for the Lake County behavioral health community to overcome but it can be done with the use data sharing agreements and change management strategies. .

## 3.2.6 LEGAL CONSIDERATIONS TO DATA SHARING

### DATA PRIVACY & SECURITY REQUIREMENTS

The laws below were cited as barriers to data sharing during the interview process and included in this section is North Highland's observations of the application of these laws within Lake County. These laws protect PII and PHI data and given that laws included vague language or room for interpretation, each organization as evaluated these laws and defined for themselves the compliance standards by which they will operate. These standards may be situational, and given this variability, organizations will need to agree to the technology and practices required pursuant to an agreed-upon interpretation of HIPAA, 42 CFR, 740 ILCS 110 and HITECH to share data.

Below is a description of the original intent of the law and observations from current data sharing assessment interviews.

#### ▪ **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

- **Regulation Purpose:** is a federal law, has multiple purposes although as it relates to sharing of information, the law outlines safeguards to protect health information while also delineating how and with whom patient health information (PHI) can be shared. It further outlines what is and is not included in the definition of PHI, as well as the responsibilities of "covered entities" such as a medical provider or health plan.
- HIPAA-compliant organizations must ensure their data-sharing partners are HIPAA-compliant. Of the rules that data sharing agreements need to comply with, HIPAA is frequently cited as easier to address.
- **Observations:**
  - Interpretation of the rule varied across organizations in regards to sharing data but all organizations required signed patient release forms prior to sharing information.
  - HIPAA-compliant organizations must ensure they have data-sharing agreements with their business associates and ensure their compliance with HIPAA. Some organizations report this as a large challenge.
  - In general, the privacy protections under HIPAA applies uniformly to all protected health information, without regard to the type of information including behavioral health. One exception to this general rule is for psychotherapy notes which have additional protections and this was recognized across all providers interviewed.
  - Providers across communities, including hospitals, view cybersecurity and technology hacks as a very serious threat and have invested significantly in both risk and compliance teams but also secure information technology. This is true with the larger provider organizations within Lake County, such as hospitals, while resources may restrict a similar investment for smaller organizations that opt to take very conservative approaches to data sharing to avoid risk.
- **Sectors Impacted:** healthcare organizations, justice system, community organizations

## Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2)

- **Regulation Purpose:** Intended to restrict the sharing of treatment information for individuals receiving drug/alcohol treatment or treatment for particular diseases. It covers the security required for both paper and electronic information.
  - **Observations:**
    - Organizations have varying understandings of the purpose and application of these regulations and to share data in the future will require an agreement on acceptable policies.
    - 42 CFR strictly limits the data that can be shared by substance abuse treatment providers, in particular.
    - While a provider may have both drug treatment programs and other services, if drug and substance abuse is the organization's most well-known service offering, confirming the delivery of patient services could be interpreted as indirectly identifying an individual as having a drug or substance abuse problem. This can cause specialized organizations to refrain from sharing data to manage risk.
    - Individuals with behavioral health needs that are also receiving treatment for substance abuse may not be differentiated within provider's electronic systems. Therefore identifying the subset of individuals on behalf of which a behavioral health and substance abuse provider can share data is more difficult.
    - Comparable communities expressed similar struggles in overcoming 42 CFR for a data sharing model as evidenced by Johnson County's long-standing efforts to recruit hospital information and new strategy of partnering with MCOs.
  - **Sectors Impacted:** healthcare organizations, justice system, community organizations

## Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110):

- **Regulation Purpose:** Illinois law intended to protect the confidentiality of records for individuals receiving mental health and developmental disabilities services. Addresses the sharing of information overall and electronically.
  - **Observations:**
    - Organizations view these rules as more restrictive than HIPAA. Some organizations disallow internal sharing of information citing these regulations.
    - Requirements for the release of information need to be specific as to the recipient and the length of time the information will be available. This requires that a system put in place has the functionality to customize the information available by person and for a specified time, which increases the amount of data management and governance required.
    - These regulations were cited the most often as the reason for not sharing information without a consent.
  - **Sectors Impacted:** healthcare organizations, justice system, community organizations

- **Health Information Technology for Economic and Clinical Health Act (HITECH) (42 USC 17935)**
  - **Regulation Purpose:** Enacted as part of the American Recovery and Reinvestment Act of 2009 to promote the adoption and meaningful use of electronic health records. Requires the appropriate security and privacy principles be applied to electronic health systems and medical records and sets up the incentive program for adopting EHRs. Clarifies record sharing among business associates and liability thereof. Provides for certification of EHR systems that qualify for the incentive program; it does not certify the entities that use those systems.
  - **Observations:**
    - Referenced in passing during interviews, and often considered within the Health IT space as a more restrictive version of HIPAA.
    - Across communities, this law is typically not as well known as HIPAA nor understood outside of risk and compliance teams. Penalties and ramifications for non-compliance are typically associated with this law, more so than the ways in which the law outlines allowable data sharing.
    - Although the availability of a certification could help in the development of the future model for the Lake County behavioral health community.
  - **Sectors Impacted:** healthcare organizations, community organizations, justice systems

## LEGAL BARRIER

### PERCEPTION OF BARRIER MAGNITUDE

The legal barriers to sharing PHI and PII are real for every service provider. For each federal or state policy, organizations can interpret the impact of the laws differently, determine impact and risk differently, and implement standards and practices to adhere to the policies accordingly. There are a few factors that can impact the perception of the legal barrier magnitude for data sharing:

- **State Laws:** If states have established stricter laws than the federal law, the state law will take precedence. The focus of such a state law can also determine the focus of its interpretation. The degree to which a state law focuses on the allowable data sharing described in HIPAA, as opposed to emphasizing the confidentiality aspects of the law, may impact how conservatively organizations interpret and operationalize legislative policies.
- **Resources:** An organizations' resources can also impact the practices in place for compliance. For instance, larger systems that can invest resources in risk and compliance and secure IT are well versed in allowable and disallowable data sharing practices pursuant to their internal policies. Hospitals are a good example of this as they manage laws to physical and behavioral health, as well as several contracts that require BAA agreements. Smaller organizations or specialized organizations may not be as well versed in all of the allowable data sharing due to resource constraints or a more narrow focus on a subset of the laws that impact their business.
- **Risk:** The risk of a data breach or violating these laws is very real to all providers. However, to a smaller provider, a single miscommunication can result in a large fine that can mean disproportionate ramifications for their ability to operate and provide services when compared to that same fine being levied against a larger organization. As a result, smaller organizations may choose to refrain from or take overly conservative approaches to data sharing.

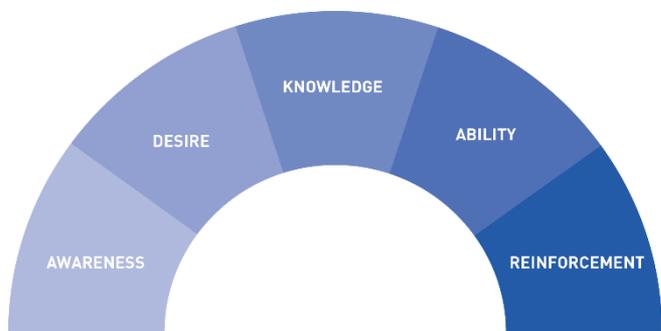
To overcome these barriers perceived in varying ways, greater education on allowable data sharing practices and on going discussion of legislation changes is needed.

Furthermore, organizations that are not covered by certain laws have fewer restrictions on sharing participant-level data. For instance, homeless organizations are able to provide information to one another to help coordinate housing opportunity for individuals through ServicePoint, and such organizations may prove a good starting point for data sharing.

## 3.2.7 CHANGE MANAGEMENT STATUS INTRODUCTION

Participation in a data sharing model will impact organizations differently, and imperative to all change initiatives is the strategic use of change levers to pull individuals and organizations through to adopting and reinforcing the change. At the onset of the project, the Coalition and behavioral health community members were encouraged to increase awareness and sponsorship for data sharing by making other community members aware of the need for change and the benefits of data sharing. The interview process increased awareness of the data sharing initiative, and engaging members of the behavioral health community during the interview process helped to create additional sponsors in addition to Coalition members.

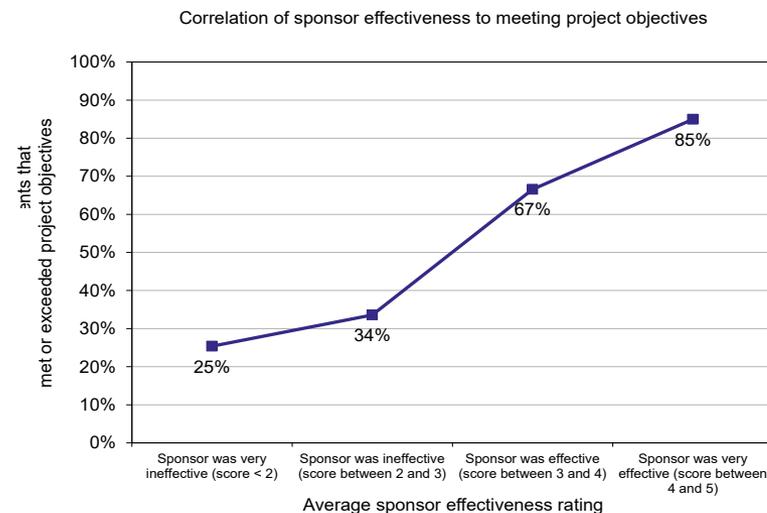
### CHANGE MANAGEMENT BRIDGE



“The Bridge Analogy”: The ability to move individuals towards adoption is dependent on laying the foundation for crossing the previous phase. The entire change management cycle fails if one component is missing.

Organizations can be pulled through a change by employing sponsorship, communications, training, coaching, and resistance management levers throughout the project duration. The Coalition has the unique challenge as it relates to change management during this project as the future vision for data sharing is not formalized yet, it will take a long time to achieve full implementation, the accountability structure spans across organizations, necessary inputs into a model may be outside of an organization’s control, and duplicative entry, time, and differing technology configurations exist across organizations.

### CORRELATION OF SPONSOR EFFECTIVENESS TO MEETING PROJECT OBJECTIVES



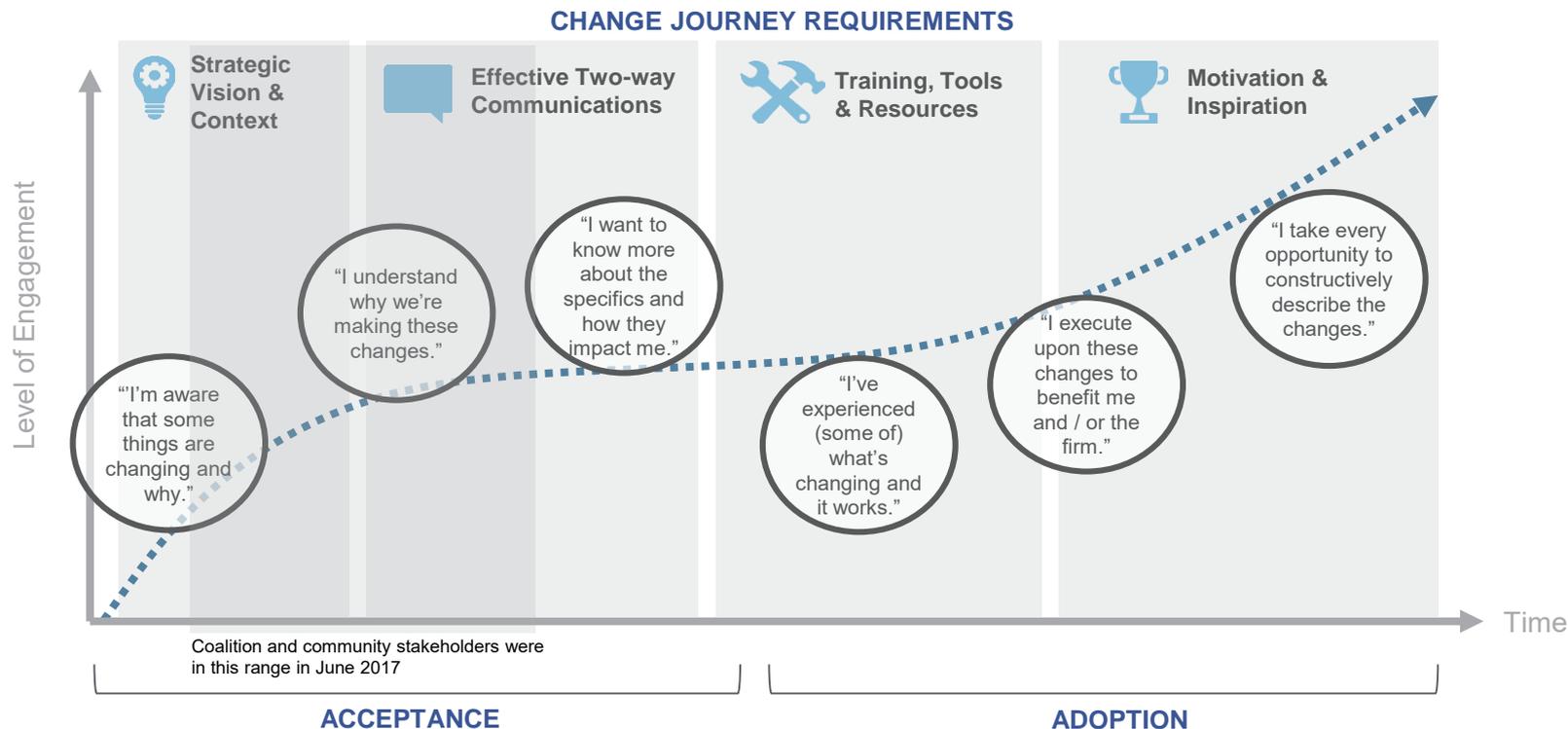
Copyright © 2014 Prosci. *Best Practices in Change Management – 2014 Edition.*

The Coalition has a unique opportunity to build greater sponsorship within the community, which can positively impact the success of the data sharing project.

Sponsors are most effective if they are strong communicators and well-respected and credible within their organization. Effective sponsors understand how the change will affect individuals’ job roles and individuals personally, reinforce the need for select activities and assist with resistance management throughout the duration of the initiative.

# CHANGE MANAGEMENT OBSERVATIONS

As individuals and organizations move along the change management curve, sponsors and managers of the change will experience varying resistance. At the time of the Current Data Sharing Assessment research, the resistance was in alignment with a transition through the awareness and desires phases of the curve. An updated assessment is available in section 5. *Recommendations* under Recommendation 3.



The range shaded above depicts the observed position of organizations along the change management curve at the time of interviews. Supporting information for this positioning include:

- The general understanding that a change is needed, but some resistance to the solution of data sharing
- The varying degrees of knowledge around what data sharing means across the community
- The uncertainty of how a data sharing program impacts specific organizations, particularly those that are perceived to be on the periphery or as addressing the societal factors of health
- The cited impact of state changes and funding challenges making organizations feel limited in their ability to move forward

### *3.3 Facilitated Discussions with the Lake County Mental Health Coalition*

## FACILITATED DISCUSSIONS SUMMARY

### COMPARABLE MODELS

During the workshops, information was presented to Coalition Members and stakeholders about several comparable data sharing communities that were researched. The content of the information presented at the workshops is contained within section 3.1 *Research Review* of this report.

Following are highlights from facilitated discussions about the comparable data sharing communities:

- NurseWise was seen as a leader in how they have partnered and organized with system partners to be able to address service needs especially for those with the highest needs in the community. Also, there was interest in how they have organized to collect and report information, and that the technology solution was developed using service dollars (Medicaid and state dollars). There was remarkable interest in the continuum of crisis services and communicated a desire to develop a similar robust crisis continuum in Lake County leading to diversion from jail and emergency departments.
- Coalition members and stakeholders were interested in Louisville Metro County as it pertains to their use of Service Point as a means for collecting and reporting data. Since ServicePoint is already being used in Lake County, it was conveyed that it should be considered as an option. There was also discussion around the expanded use of Service Point and the corresponding compliance review process underway. Coalition members and stakeholders liked how the Louisville Metro program allowed referrals into the program from multiple points. Further, participants expressed interest in this model because the community was able to identify individuals who needed services but could also identify those with high utilization between system partners.
- Coalition members and stakeholders liked the patient-centered care approach that is utilized by several communities, in particular, the Camden Coalition and King County Familiar Faces programs. Coalition members and stakeholders discussed how a person-centered approach is essential to making a difference in addressing the needs of individuals and families. The person-centered approach allowed the community to develop focused initiatives to address the specific needs of the individuals.
- The Coalition also focused on how each community paid for their data sharing initiative. It was recognized that the Camden Coalition model benefitted significantly from private funding that afforded the robust technology and analytics resulting in “hot spotting” to identify those with the highest needs. There was interest in that several communities paid for organizational technology through service funding (e.g. private insurance or Medicaid).
- There was interest in those communities that were able to utilize data to identify those with the highest needs or highest use of services across systems.
- In line with the desire to get started, Coalition members liked how several of the communities began small and developed enhanced sophistication in data sharing overtime. Coalition members recognized the need to sequence the addition of system partners and integration of additional data points.

# FACILITATED DISCUSSIONS SUMMARY

## KEY INFORMATION / DECISIONS NEEDED

There were three themes that emerged from past research, Current Data Sharing Assessment interviews, coalition meetings and discussions as to the questions for which the Lake County behavioral health community would like answers. These are in alignment with the larger questions that North Highland has seen other communities answer when addressing behavioral health related issues.

The three themes were:

- Who is in need of or seeking behavioral healthcare?
- Are the service needs of those accessing behavioral care being met?
- Are the services provided impacting outcomes and making a difference for individuals and families served?

Coalition members and stakeholders agreed that the first two aforementioned questions were seen as the most logical place to start seeking answers and that the third question should be considered during the development of a data sharing program so that it can be folded into the future data sharing model at a later time.

There are more specific questions that can be asked related to the aforementioned, predominate themes of information desired. The following questions are those that the County raised as primary concerns during the visioning session, in current data sharing assessment interviews, and during the workshops. The full list of related questions can be found in *Appendix 12. Systemic Questions to Prioritize – Workshop 1*.

### 1. Who is in need of or seeking behavioral healthcare?

- How many individuals/families are receiving services (over the past month)?
- How many new individuals/families are accessing services (over the past month)?
- What are the demographics (e.g. zip code)of those seeking services?
- What behavioral health conditions are individuals/families seeking services for (e.g. relationship problems, psychosis, depression, suicidal thoughts/actions, substance abuse/dependence, anxiety, etc.)?
- What are the co-occurring conditions for individuals seeking services?
- In the aggregate, what are the overall service intensity needs of the individuals/families (e.g. high, medium, low intensity need)?

### 2. Are the service needs of those accessing behavioral care being met?

- *Timelines of services:*
  - Are routine services provided within a pre-determined time standard?
  - What is the average length of service duration for routine services?
  - What is the length of time to access care (by payor, by service)?
    - Timeliness of disposition out of the ED (by Payor)
  - Where was the individual discharged?

# FACILITATED DISCUSSIONS SUMMARY

## KEY INFORMATION / DECISIONS NEEDED- CONTINUED

### 2. Are the service needs of those accessing behavioral care being met?

- *Recidivism:*
  - *What does the recidivism look like across services within 30/60/90 days?*
  - *Who are the high utilizers within the community?*
- *Service Capacity:*
  - What is the current Professional and or bed capacity per population ratio?
  - What does the justice system preparedness and response to behavioral health look like?

### 3. Are the services provided impacting outcomes and making a difference for individuals and families served?

- Has life functioning improved for certain individuals?
- What are the trends in demand and capacity over time?

The answers to these more-specific questions can help answer the broader theme questions as the answer to those theme questions can be multidimensional. Additionally, using these questions to deduce the data needed can help Lake County focus on which data points to share and the data points that can have the greatest ability to answer the most questions.

Following the discussion about prioritizing key information/decisions are needed during the workshops, the Coalition Members and stakeholders were led through a process to explore what data points/data metrics could be used to answer the prioritized questions.

The below data points were suggested by the Coalition members and stakeholders as being beneficial in answering questions. These are not presented in a prioritized order and the availability of these metrics within some organizations requires further research.

- Individuals with behavioral health conditions
- Timeliness service capacity
- Requests for beds
- Number of individuals receiving behavioral health services
- Individuals receiving behavioral health services by payor
- Referral service
- Demographics
- BH conditions and co-occurring conditions
- Access to primary care
- Length of wait time for appointment
- Number accessing the ED
- Number by payor source
- Cooccurring conditions
- Inmate pop with behavioral health needs
- Recidivism for all services (crisis services, emergency department, jail, etc)
- Prevalence of behavioral health needs within the jail and probation populations

The list above contains both aggregate information about service capacity at an organizational level as well as participant level information related to individuals' health and outcomes. Both types of information will be needed to answer the theme questions, however accessing and sharing participant level information will require overcoming additional barriers as documented in the previous research sections.

Many of the above statistics are related to the health sector. However to have a system-wide data sharing model, data points from the justice and community organizations that can help answer the theme questions will need to be included in a future model. Examples include, number of probationers in need of counseling, housing status per person and total number of individuals with BH needs seeking stable housing.

A full list of the data points that can be collected and or shared to answer the theme questions is available in Appendix 7.10 Data Matrix.

## FACILITATED DISCUSSIONS SUMMARY

### THEORETICAL AND PREFERRED DATA SHARING MODELS

Upon review of the Theoretical models,

- Coalition Members and stakeholders expressed that to realize any future data sharing model, there would need to be a staged approach and a roadmap to follow.
- Coalition members recognized that although a point to point model could benefit one or two organizations, it would not be an ideal model for the community as a whole as it would not allow insight into the entire system.
- Coalition and behavioral health community members had a preference for the central repository model for several reasons. It can accommodate data being received from disparate systems. Further, having data from different systems into one place would allow for community-wide data reporting through a reporting tool.
- Coalition members and stakeholders saw the option of using a staged approach with a central repository by first collecting aggregated data and later collecting participant-level data as a viable option for Lake County.
- A central repository's ability to cross reference individuals across service providers was particularly attractive to those who see a need to identify and address the needs of behavioral health individuals with high utilization across systems.
- Coalition members liked that a central repository model would offer flexibility to allow new organizations to be added over time and to continue to expand the data points collected to address the evolving needs of the community.
- Hybrid models (including the use of a HIE) were identified by some as the preferred model but Coalition Members and stakeholders also recognized the need to move along a staged approach towards this longer-term, complex model.

---

---

## 4. Data Sharing Project Findings

## 4. DATA SHARING PROJECT FINDINGS

### INTRODUCTION

This section outlines North Highland's findings attained through the course of the Data Sharing Project. The findings were developed subsequent to synthesizing the following information:

- Information obtained through a research and discovery process as described in section 3.1 *Research Review*, including:
  - Prior reports/evaluations of Lake County initiatives
  - National and local trends impacting behavioral health
  - Comparable data sharing models from other communities
  - Theoretical model review
  - Data governance approaches
  - Data sharing agreements
  - Laws impacting sharing of data in Lake County
  - Data security and privacy best practices
- Information obtained during the Current Data Sharing Assessment of the Lake County behavioral health community, as documented in section 3.2 *Current Data Sharing Assessment*, including:
  - Sector strengths, “what’s in for me”, opportunities and barriers
  - Sector process and data flows
  - Current data sharing technology
  - Current data sharing availability and existing partnerships
  - Barriers to data sharing
  - Legal considerations to data sharing
  - Change management status
- Information surfaced through facilitated discussions with the Coalition and stakeholders, as documented in 3.3 *Facilitated Discussions with the Lake County Mental Health Coalition*.

The following findings are presented in no particular order or sequencing as the information contained within a category is often intertwined and connected with content within other categories.

## DATA SHARING PROJECT FINDINGS

### LAKE COUNTY BEHAVIORAL HEALTH COMMUNITY STRENGTHS

The Lake County behavioral health community has many strengths it should draw upon as it moves forward with its Data Sharing Project. The following initiatives, programs or collaborations/alliances are a few examples of the positive activity within the Lake County behavioral health community:

- Conducting Mental Health First Aid training
- Conducting CIT training for emergency response personnel and sworn police officers
- Using trauma-informed approaches, such as facility dogs in the Child Advocacy Center
- Implementing A Way Out program that is a cross-system collaboration facilitating access to substance abuse treatment
- Facilitating a community-wide health and wellness initiative through Live Well Lake County
- Mobilizing care coordination best practices through the Mental Health Collaborative
- Being inclusive of organizations and stakeholders that represent the voice of individuals and families with behavioral health needs;
- Implementing initiatives that work to identify those with the highest needs and are frequent utilizers of cross-system services (e.g. Top 100 jail utilizers initiative)
- Mobilizing on several justice initiatives (e.g. transition to the community enhancements)
- Using Service Point as central repository for various initiatives
- Having industry-specific trade organizations provide educational and advocacy support the development of organizations, such as the Alliance for Human Services

## DATA SHARING PROJECT FINDINGS

### TECHNOLOGY INFRASTRUCTURE AND DATA SHARING

As with all communities throughout the nation that seek share cross-system data and information, the Lake County behavioral health community needs to have a technology infrastructure that can support the collection and reporting of integrated information. Currently, there is not a technology solution within Lake County that can immediately be used to collect and report information **across systems** for the Lake County behavioral health community. A Information about the current technologies used throughout the Lake County behavioral health community is available in section 3.2. *Current Data Sharing Assessment*.

#### Findings:

- A technology solution will need to be planned for, designed and developed. The solution should build upon existing systems, other strengths within Lake County, and best practices learned from other data sharing communities. Further, tandem to developing the technology solution, research will need to be conducted to identify sources of financial support that are also sustainable. Decisions such as build or outsource a solution will need to be part of an implementation plan.
- The solution should begin with a simple, low-tech approach that can garner early wins and simultaneously work to design a technology solution that will support the Lake County behavioral health community in its efforts to excel in care coordination activities and have readily available information for planning and oversight of the system.
- At present, there is minimal **electronic data sharing** for care coordination and there is no **cross-system aggregated data** available for **behavioral health system** planning and oversight, except for homelessness information that provides insights into a societal determinant of behavioral health. Sharing information *between system partners* for behavioral health information *primarily* is in the form of telephone calls or facsimiles.
- There are a few examples of technology being utilized in Lake County to electronically transmit data and calculate data in an aggregated form for planning and oversight. Examples of electronic data sharing within Lake County include:
  - The use of Service Point within the behavioral health community as a care coordination tool that enables the collection, transfer and aggregating of data across **some** systems or between organizations. Service Point enables a real-time referral network across system partners, including organizations in the healthcare, justice, and community sectors. The referral network tool has been used for various projects and established processes. Examples of this include probation referrals to behavioral health providers and community service providers to physical healthcare providers. Additionally, within the homelessness community, the real-time referral network tool facilitates access to housing services based on prioritization criteria across the community. Further, the way Service Point is used within the homeless community allows for the reporting of information in an aggregated manner that supports planning and oversight tasks.

## DATA SHARING PROJECT FINDINGS

### TECHNOLOGY INFRASTRUCTURE AND DATA SHARING

- The Lake County justice system partners, including law enforcement, jail, and courts (including probation), utilize both shared and disparate systems. The disparate systems have varying capabilities to share and update data between systems.

Although these are examples of technology being used to electronically share data, these systems ***do not nor were intended to serve as a mechanism to interact with behavioral health data as a whole***. As a future technology solution is designed for the Lake County behavioral health community, it should certainly utilize and leverage the strengths of these systems.

There were mixed opinions by system partners on the expansion of Service Point technology to share data between system partners. There were system partners that were effectively using Service Point and conveyed that an expanded use could be an option moving forward. However, other system partners who have attempted to use Service Point as their primary electronic tool to record service provision were not satisfied with the use or flexibility of Service Point. Finally, there is a current assessment in progress that will provide written findings with a determination if Service Point adheres to HITECH requirements as prescribed for health care providers, including behavioral health providers.

Several of the comparable data sharing communities researched offer insights into best practices and lessons learned that can help inform the Coalition in developing a technology solution for cross-system data sharing. Some of the insights include developing a data sharing vision, utilizing a staged approach towards the vision, and building upon existing technologies that are in alignment with the vision wherever possible.

## DATA SHARING PROJECT FINDINGS

### DATA GOVERNANCE

Industry best practices, regarding data collection, analysis, and reporting that is within or across organizations, require that all aspects of governance related to people, processes, and technology must be established and addressed. Data governance approaches that enable success are comprehensive in nature. Several key tactics for data governance that must be employed include, but are not limited to: agreement on data standardization, data quality, technology, security and privacy, and adherence to and compliance with regulations.

Within Lake County, North Highland found that there are a few examples of data collection, analysis, and reporting that utilize some application of data governance approaches. For example, several service providers including the homeless community, probation, community behavioral health providers, and the jail use Service Point, and the homelessness organizations have a standardized set of data against which to assess need. However, there is no current cross-system data governance approach for the Lake County behavioral health community and this will need to be established.

As organizations come together to share data, it will be the Data Governance representatives that shape what data can be shared and how data can be shared based on their internal systems, access to data, and restrictions, including compliance.

Additional information on data governance practices can be reviewed in section *3.1.5 Data Governance Approaches*.

# DATA SHARING PROJECT FINDINGS

## DATA GOVERNANCE

### Data Sharing Agreements:

Best practices for cross-system data sharing require formalized agreements to assist organizations, or a group of organizations, to outline the terms and commitments of sharing data with one another. There are many types of agreements with varying content that can be used to address the specific nature of a data sharing arrangement, such as Memorandums of Understanding (MOU), Data Sharing Agreements, Data Use Agreements, and Business Associate Agreements.

Although there are some agreements within small pockets of data sharing within Lake County (e.g. use of ServicePoint), there **currently are no written data sharing agreements** that would support sharing data across multiple system partners within the Lake County behavioral health community. Documents that could be used for reference to create data sharing agreements include ServicePoint's *User Policy, Responsibility Statement & Code of Ethics*, existing point-to-point or grant-related agreements, and comparable community agreements.

Additional information on data sharing agreements can be reviewed in section *3.1.6 Data Sharing Agreements*.

## DATA SHARING PROJECT FINDINGS

### DATA AVAILABILITY

In order to address the information needs of the Lake County behavioral health community that will allow for planning and oversight tasks, it is necessary that:

- Standardized data be available within cross-system organizations that interact with individuals and families with behavioral health needs
- Individual or aggregated data be transferred to a central repository
- The centralized data is analyzed and reported on

The current types, amount, format, and sharing of the data available in the Lake County behavioral health community ***is currently not sufficient*** to provide the desired information consistent with national best practices and prioritized data identified through this project.

Although there is ***some*** data collected that is consistent with best practices for behavioral health communities, there is a need to standardize the data that is collected, and there is significant opportunity to add additional data points within all sectors to support the information needs for planning and oversight tasks.

Of note, it was revealed during the Current Data Sharing Assessment that some organizations, including behavioral health providers, do not use an electronic system for collecting information or they collect the information in spreadsheets for their internal reporting. These organizations will need to have a customized plan to progress and begin using electronic data system and share data electronically.

Additional information about data availability and prioritized data can be reviewed in the below sections:

- *3.2 Current Data Sharing Assessment* specifically within *3.2.4 Current Data Sharing Availability and Existing Partnerships*
- *Appendix 7.10 Data Matrix – Extended List of Data / Measures*
- *3.4 Facilitated Discussions with the Lake County Mental Health Coalition*

## DATA SHARING PROJECT FINDINGS

### BARRIERS TO OVERCOME

Barriers to data sharing within the Lake County behavioral health community were identified through reviewing the research and conducting the Current Data Sharing Assessment.

Legal, technical, and operational barriers to data sharing were identified. A summary and analysis of the barriers can be reviewed in the Current Data Sharing Assessment section *3.2.5 Barriers to Data Sharing* and *3.2.6 Legal Considerations to Data Sharing*.

The identified barriers range in their level of complexity and will require varying levels of sophistication to overcome. Barriers were perceived differently by the various stakeholders interviewed. As each organization has different challenges and capabilities, in order to be able to participate in data sharing, each will need to have individualized paths and starting points. These custom paths do not preclude data sharing activity nor working towards common goals, rather they enable each organizations to contribute at the level they are able to when they are able to do so.

Barriers will need to be overcome at the organizational level and at the system level to implement a data sharing model. The highest barriers for organizations to overcome include concerns about data governance, reporting capability, and allocation of resources. In fact, at the system level, the Lake County behavioral health community will face challenges as all organizations weigh conflicting priorities and opportunities costs to participating. Laws that protect PII and PHI were often cited as barriers to data sharing and participating organizations will need to be comfortable with the compliance of the future data sharing model.

Some barriers can be overcome with additional stakeholder clarification and education. Other barriers can be overcome through the design and implementation of technology and processes. For example, technology and processes will need to be designed to:

- Address organizations' reporting, data governance, and resource concerns;
- Alleviate the community's challenges of engaging organizations to participate in light of conflicting priorities;
- Support the Lake County behavioral health community in balancing and emphasizing the value of data sharing with the costs of participating; and
- Enable the flexibility to adapt to new strategies as they arise and address changes outside the control of organizations and the Lake County behavioral health community, such as Medicaid or MCO initiatives.

Processes for addressing these concerns are included in section *5.1 Recommendations*.

## DATA SHARING PROJECT FINDINGS

### BARRIERS TO OVERCOME

There were no barriers identified that cannot be addressed through technology, processes, education or advocacy. Although significant thought and agreement between system partners on how to design a solution to address some of the more challenging barriers, such as the legal barriers to sharing PHI.

The laws cited as restricting data sharing are real barriers to sharing participant-level data are designed to protect PII and PHI data, not aggregated data. Organizations varied in their compliance practices to meet all laws protecting PII and PHI due to interpretation, resources, and risks, and greater education around allowable data sharing can help organizations within Lake County recognize additional data sharing opportunities. To share data, and in particular participant-level data, organizations should work together to provide input, standardize practices, and ensure that the agreed-upon practices for the model meet the organizations' risk and compliance needs. Additional information on this type of data governance can be found in section *5.1 Recommendations, Recommendation 2*.

740 ILCS 110 focuses on the confidentiality aspects of HIPAA which creates an additional barrier to data sharing for behavioral health providers in Illinois. Similar to HIPAA, 42 CFR, and HITECH, organizations determine how to operationalize the legislation and the law's focus on the confidentiality and restrictions on data sharing can result in a focus on restrictions rather than allowable data sharing. Additionally, this law is in addition to HIPAA and has such add more complexity, as evidence through organization – specific release of information forms. This barrier may be overcome with a significant and concerted effort to amend the additional restrictions beyond HIPAA and further support data sharing or policies/practices. For more information see section *5.1 Recommendations, Recommendation 7*.

## DATA SHARING PROJECT FINDINGS

### HEALTH AND HUMAN SERVICES

National and local health and human services initiatives, inclusive of behavioral health initiatives, are exponentially changing the paradigm on how care is delivered and managed, including utilizing data to facilitate care, inform planning, and oversee system delivery.

The Lake County behavioral health community has opportunities to become more engaged in and aligned with national and local initiatives that are parallel to and support the Coalition’s vision, goals, and guiding principles as outlined in *Appendix 7.1 Lake County Mental Health Coalition Charter*. Although there are some examples within the Lake County behavioral health community of embracing and mobilizing on the changes underway, it was observed that the **Lake County behavioral health community as a collective is not aware of or collectively embracing these opportunities**. When compared to other communities nationally and locally, the Lake County behavioral health community has opportunities to enhance its care delivery continuum and clinical and operational practices. Summary information about the current operations, strengths, barriers, and opportunities within the healthcare sector including behavioral health can be reviewed in section *3.2.2.1 Healthcare Organizations*.

Examples of the initiatives and operational paradigm shifts that can be further acted upon within Lake County behavioral health community include but are not limited to:

- Employing strategies to achieve the Triple Aim, a concept in healthcare developed by the Institute for Healthcare Improvement (IHI) to frame solutions to addressing the problems with the nation’s healthcare system (including behavioral health). The goals of the Triple Aim are to:
  - Improve the experience of care
  - Improve the health of populations
  - Reduce the per capita cost of healthcare

Additional information about the Triple Aim and other national healthcare and behavioral health trends and practices can be reviewed in section *3.1.2 National and Local Trends Impacting Behavioral Health*.

- Accelerate an understanding of and develop strategies to participate in the Illinois HHS Transformation as it will significantly impact the delivery of behavioral healthcare throughout Illinois. Additional information about the HHS Transformation can be reviewed in section *3.1.2 National and Local Trends Impacting Behavioral Health*.
- Transform the delivery system through an expansion of the continuum of care including support and crisis services that are in alignment with the HHS Transformation and national best practices for support and crisis services. Additional information about the HHS Transformation and national best practices about support and crisis services can be reviewed in section *3.1.2 National and Local Trends Impacting Behavioral Health*.

## DATA SHARING PROJECT FINDINGS

### INFORMATION DESIRED AND NEEDED BY THE LAKE COUNTY BEHAVIORAL HEALTH COMMUNITY

As with all communities throughout the nation, it is essential that the Lake County behavioral health community has system-wide information to support future planning and oversight of the behavioral health delivery system and care coordination efforts. The following are findings of the essential information desired by the Lake County behavioral health community:

- There was general agreement among stakeholders that the information desired by the Lake County behavioral health community must be collected and reported on in a manner that expresses the complexity of a cross-system collaboration working to assist, support, and serve individuals and families with behavioral health needs.

This cross sector approach can enable insights into the whole health of the patient including physical, behavioral, and social determinants of health and is needed to have a system-wide perspective.

- There were three key themes about the types of information desired that repeatedly surfaced during both interviews and other discussions. The themes were related to the following three questions:
  - Who is in need of or seeking behavioral health care and what services do they need?
  - Are the service needs of those accessing behavioral care being met?
  - Are the services provided impacting outcomes and making a difference for individuals and families served?

Additional information about the themes and questions is available in *Appendix 12. System Questions to Prioritize- Workshop 1*. These first two questions are needed to understand the demand and supply of behavioral health services within Lake County, while the third question will be required to address more complex outcome analysis and to measure impact.

- There was general agreement that the desired approach for the data sharing project should prioritize what questions needed answers, in order to define the data needed to answer those questions. The first two theme questions were seen as the most logical place to start seeking answers and to keep the third question in mind throughout the development of the model to then address it in later stages.

Example data points prioritized by the Coalition to answer the first two theme questions include:

- Number of individuals accessing the ED
- Number of individuals with different diagnosis
- Length of time for appointment
- Recidivism for all services (crisis services, emergency department, jail, etc.)
- Number by payor source

## DATA SHARING PROJECT FINDINGS

### INFORMATION DESIRED AND NEEDED BY THE LAKE COUNTY BEHAVIORAL HEALTH COMMUNITY

This sequencing preference is inline with the data available as service level data can be made available in aggregated form while demand can initial be provided as an aggregated for all unique users and then by each unique user.

These data points are some of the key data points that can help answer the first two theme questions and additional data points to considered are located in section 5.1 Recommendations under Recommendation 2.

- Through the facilitated discussions, it became clear that stakeholders grasped the complexity of obtaining information within a cross-system collaboration and that any activity relating to obtaining information would need to include but not limited to:
  - Sequencing of what information is shared
  - Sequencing of what entities would provide what information
  - Phasing of what technology is used to collect data that would be converted to information

A clear sequence of events, responsibilities and technology evaluation is needed to make sure that the solution that is developed is the best fit for the desired and needed functionality of a data sharing model.

#### Some elements that are needed but were not discussed as being desired include:

The type of data: There are several aspects to data sharing that support answering the three theme questions that also need to be included in a future data sharing model.

- For the first and third theme questions, identifiable participant level information needs to be shared to measure the true need and trends overtime. To link participant information from different systems requires a process by which like participants are matched and deidentified as appropriate.
- To answer the second question, access to back-end data, such as time stamps for specific information can help assess the timeliness of services.
- Reporting capabilities must be in place to extract and display the data

Data Standards: There were virtually no standardized performance measures published or agreed upon to evaluate the performance of the behavioral health delivery system (e.g. timeliness of services). Although some behavioral health providers have internal measures to assess their internal operations, such measures are not published.

Prioritization of key data points: Several of the comparable data sharing communities researched have identified the information and supporting data they prioritized for their community and could be leveraged. An example of this is found within the National Crisis Services Trends in section 3.1.2 *National and Local Trends Impacting Behavioral Healthcare*.

---

## **5. Data Sharing Vision and Data Sharing Project Recommendations**

## *5.1 Data Sharing Vision*

## DATA SHARING VISION

One of the essential steps to **advancing sustainable community-level change through a system-wide data sharing initiative** within Lake County is for the Coalition to come to general agreement around a Data Sharing Vision. A vision provides a general framework to work towards, and as time passes, this vision is subject to change to adapt to the needs of the Lake County behavioral health community and external factors.

Having a guiding vision can then enable the Lake County behavioral health community to “just get started” with actions towards its purpose and design, and this action can help the Lake County behavioral health community recognize small wins from sharing data. These wins are described in detail throughout this report and can include, but are not limited to, improved participant experience, care coordination, and operational efficiencies.

This vision was developed from all of the aforementioned activities in the Data Sharing Project, and incorporates the feedback, preferences, and challenges communicated during facilitated discussions with Coalition Members and stakeholders.

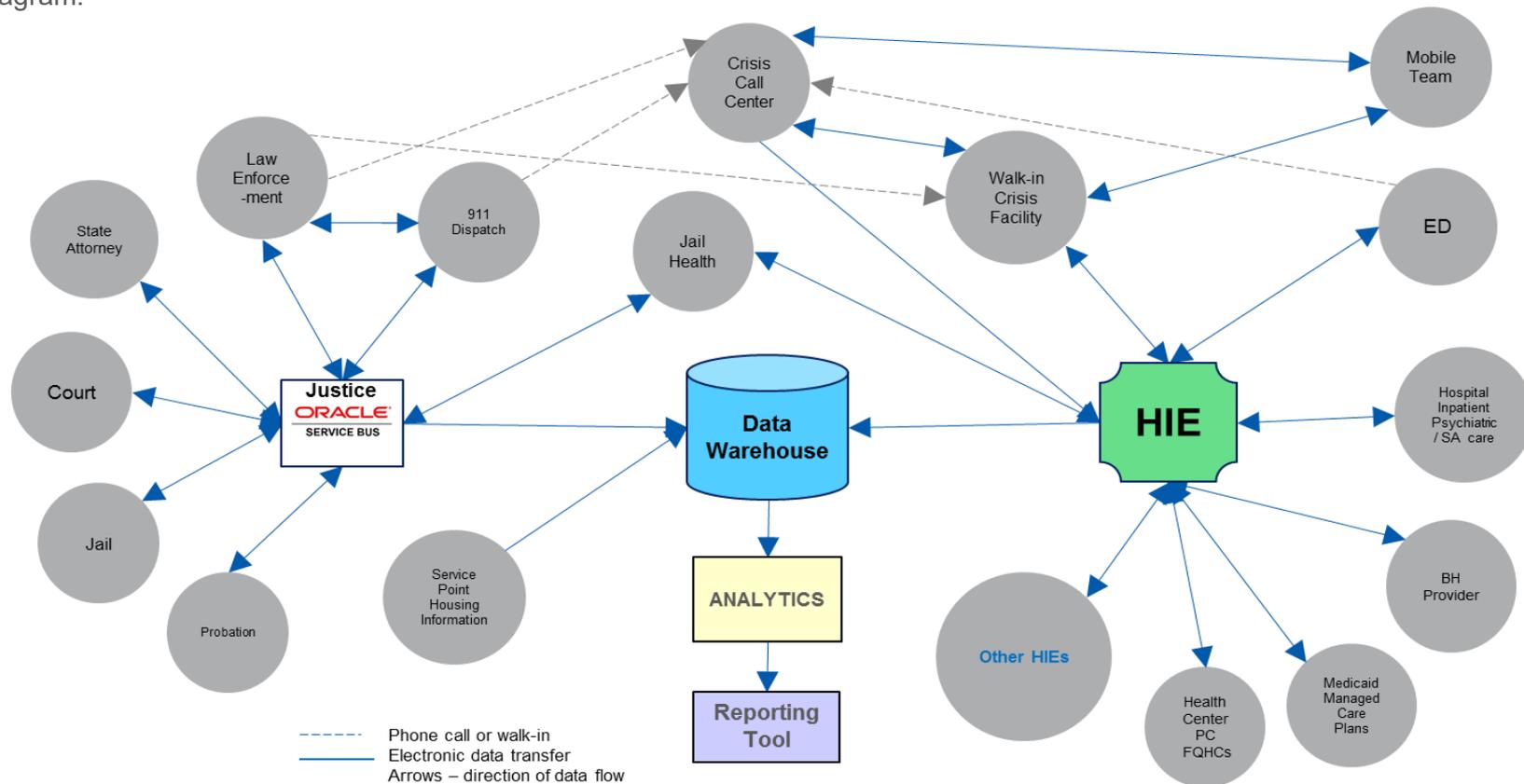
The following is intended to illustrate the process of arriving at the long-term goal by understanding what can be done in the near term and providing direction.

- Extended Long-term View
- Data Sharing Vision

# EXTENDED LONG-TERM VIEW- HYBRID MODEL FOR DATA SHARING

Coalition Members and stakeholders conveyed a desire to have a hybrid model of data sharing. Based on the research conducted, a hybrid model provides for a sophisticated approach to care coordination, analytics, and reporting. However, this model will take an extended length of time to realize and involve stakeholders beyond the Lake County behavioral health community. Given the time it takes to establish this complex data sharing network, the hybrid model below is subject to change.

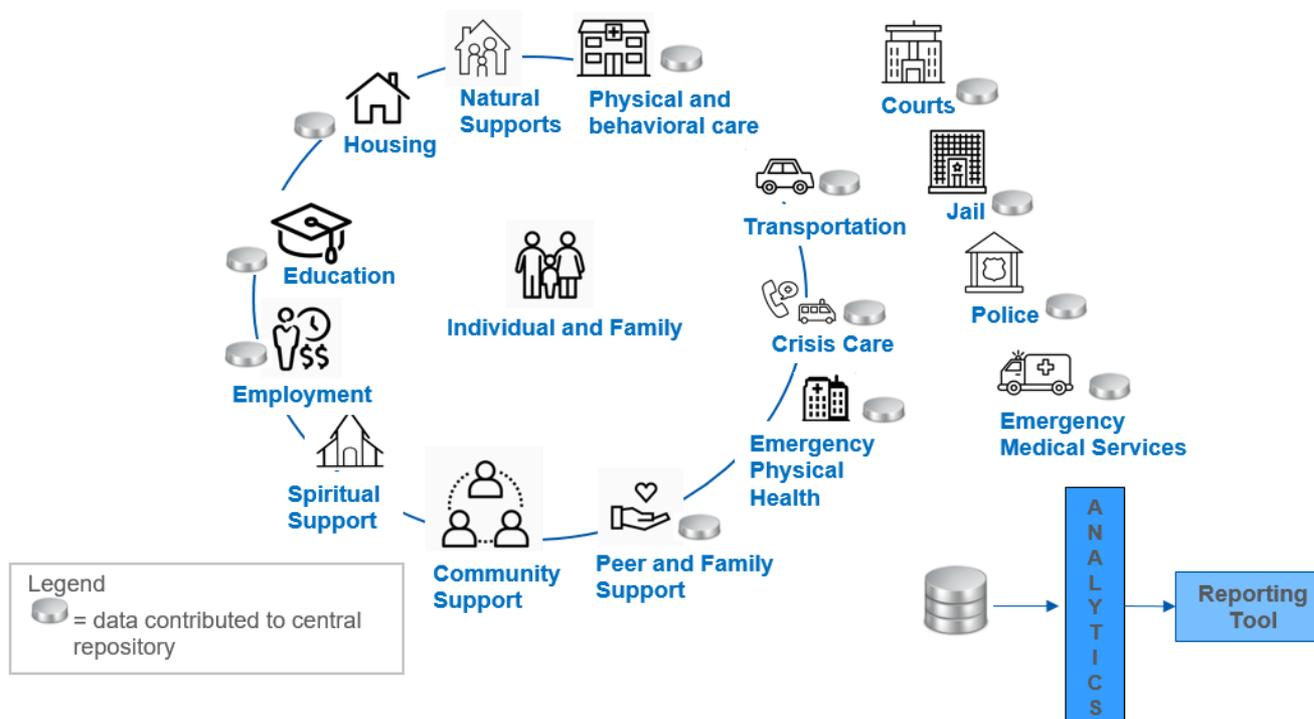
As such, the Coalition can embrace this extended long-term view for the future while **working towards an achievable Data Sharing Vision for that Lake County behavioral health community** that will naturally move towards a hybrid model similar to the below diagram.



## PROPOSED DATA SHARING VISION

The Data Sharing Project research and facilitated discussions support the Coalition in adopting a person-centered Data Sharing Vision that utilizes a data warehouse for a central repository that contains participant-level data. This model is similar to the comparable models preferred by the Coalition and stakeholders during discussions and allows the Coalition and community members to recognize answers to their prioritized goals and questions. This model will enable care coordination, analytics, and reporting to support planning and oversight tasks. Not all services may be available today, such as crisis mobile teams, and organizations may serve multiple functions and thus fall in more than one of the below categories. Regardless of category however, the focus of the data shared and model developed should be on the participant and this vision will serve as a guide when pursuing chosen recommendations and subsequent “Go First Strategies.”

Lake County Mental Health Coalition Proposed Data Sharing Vision



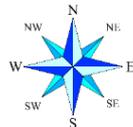
- System partners submit individual participant-level or aggregated data to the central repository data warehouse and the data warehouse has look-up capabilities for allowable entities/roles.
- The Data Sharing Vision will be implemented in a manner that is consistent with the Coalition’s Guiding Principles as outlined in *Appendix 1: Lake County Mental Health Coalition Charter*. A detailed implementation plan that identifies roadmaps to enable organizations’ participation in this model and efforts towards this vision should be developed.

## *5.2 Recommendations*

# DATA SHARING PROJECT RECOMMENDATIONS

## INTRODUCTION

Recommendations were developed to move the Lake County behavioral health community towards the Data Sharing Vision by synthesizing all the information obtained through the activities of the project including those described in *3.1 Research Review*, *3.2 Current Data Sharing Assessment*, *3.3 Facilitated Discussions* and *4. Data Sharing Project Findings*. These recommendations are directional in nature as how they are operationalized per organization can differ. This directional quality is symbolized by a compass throughout the remainder of the report.



The following recommendations address the short-term and long-term needs of the initiative that will result progressing towards the Data Sharing Vision. The recommendations start with a model framework for data sharing and outline the needed actions to establish, maintain, and support enhanced data sharing within the Lake County behavioral health. The order of the recommendations do not convey sequencing or order for action.

**Model Recommendation:** The analysis of the aforementioned research drove the design of a staged approach to recognize the benefits of data sharing overtime while organizations overcame their respective barriers to data sharing. Included in this recommendation is a description of the different stages to reach system-wide insights, the value each stage can bring, and the prioritized questions that can be answered in each stage.

**Supporting Recommendations:** Additional recommendations should be pursued to support the success of the data sharing model. These additional recommendations include organizations collecting, standardizing, aggregating, and sharing multiple levels of data to ultimately reach a point where the information shared can provide insights into the unique number of individuals with behavioral health issues and their needs. The recommendations to support a data sharing model include data governance structures, legal adjustments, change management, MCO and Medicaid Agency involvement, service expansion, and funding research are required to recognize the many goals of data sharing.

A future project plan will need to be developed that outlines sequencing and assignment of responsibilities for tasks needed to address these recommendations.

## RECOMMENDATIONS OVERVIEW

Below is a list of North Highland's recommendations to pursue a future data sharing model within Lake County. Each of the below recommendations are detailed in the following respective sections.

**Recommendation 1:** Implement a staged approach to data sharing that ultimately results in a centralized *data warehouse with participant-level data*. This will enable the collection, analysis, and reporting of both aggregated and participant level data metrics and supports care coordination through look-up capabilities

**Recommendation 2:** *Implement Data Governance Structures, Standard Operating Procedures, Security, and Processes* to support sustainable success of data sharing.

**Recommendation 3:** *Formalize Change Management Structures* to support continued engagement with the Lake County behavioral health community through all stages of the future data sharing model development and supporting activities

**Recommendation 4:** *Foster relationships with the Illinois Medicaid Agency and Medicaid Managed Care Organizations (MCOs)* to align with common goals and strategies for data sharing and delivering exceptional behavioral healthcare.

**Recommendation 5:** *Support learning opportunities* to enable exceptional care and business operations for behavioral health service providers.

**Recommendation 6:** Support *expansion or shifts in the behavioral health services continuum* to better align services with community needs.

**Recommendation 7:** *Influence federal and state laws* that support the active sharing of information to coordinate care, while also safeguarding privacy.

**Recommendation 8:** *Explore potential funding mechanisms* to establish a financially sustainable data sharing program.

# RECOMMENDATIONS OVERVIEW

In addition to recommending a future data sharing model, North Highland included several recommendations that address the challenges that Lake County faces when establishing a data sharing model to complement the development of a data sharing model and help support its success. A high-level review of these challenges is below and greater detail behind these recommended mitigation strategies are included in recommendations two through seven.

## Challenges

**Data Ownership:** the Coalition or a third party are not the owners of the data nor of a substantial data set (such as claims data) as would be the case if it was the sole provider.

**Organization:** In some comparables, governing bodies own two key system partners, such as courts and police or an MCO and healthcare provider.

**Missing Data:** Claims data has enabled several of the comparable models and would answer many of the Coalition's prioritized questions, but is currently not available. The lack of select crisis services such as a mobile team, means that key crisis information is not being captured in the community which is critical for diversion measurements. Currently Crisis calls are received via a crisis hotline and the police, but the data is not aggregated.

**Inconsistent or Unavailable Data:** Data exists across-sectors and programs and in many different forms and, to share data

**Sponsorship:** Turnover and succession planning is critical for long-term momentum on multi-year initiatives.

**Varying Interpretations of the Law:** Sharing aggregate level data will largely be dependent on the willingness of the organization and its internal policies. Sharing patient-level information would benefit from updating laws to recognize changes that promote data sharing

## Recommendation Mitigation Strategies

**Data sharing agreements:** Execute agreements with the owners of the data outlining how the data will be communicated, stored, accessed and used.

**Change Management:** Begin establishing a partnership with MCOs and Medicaid agencies

**Change Management:** Ensure the right players are at the table and that the data sharing program has the appropriate sponsorship across-sectors and players by getting the MCOs involved.

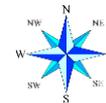
**Expand Services:** Build a roadmap to develop services that can measure missing data within the community and can help Lake County recognize a robust data sharing program strategically

**Data Governance:** Task data stewards and teams to define data standards based on availability and quality

**Change Management:** Ensure the momentum of the project continues through expanded sponsorship and stakeholder management.

**Legal Action:** Work with policymakers to repeal, amend and provide clarity to laws impacting data sharing. Determine a middle ground or standard across organizations through a governance committee.

**Data Governance & Agreements:** Build teams to define and agree to standards and come to an agreement for future processes.



## NORTH HIGHLAND RECOMMENDATIONS

### FUTURE DATA SHARING MODEL

**Recommendation 1:** Implement a staged approach to data sharing that ultimately results in a centralized *data warehouse with participant-level data*. This will enable the collection, analysis, and reporting of both aggregated and participant level data metrics and supports care coordination through look-up capabilities.

**Recommendation 1.1:** Begin a staged approach to data sharing by implementing a *Data Sharing Pilot Project* engaging system partners from across-sectors, such as behavioral health providers, emergency departments, Lake County Jail and Lake County Probation. The focus of the Data Sharing Pilot Project would be on simple, low tech solutions to collect a prioritized list of aggregated data metrics.

**Recommendation 1.2:** Implement the next stages of the *staged approach to data sharing* advancing more sophisticated ways to collect aggregated data and adding additional organizations to the data initiative, ultimately driving towards a *Data Warehouse with participant-level data*. Implement the next stages based on lessons learned from the Data Sharing Pilot Project.

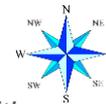
**Recommendation 1.3:** Detail the business requirements for the overall solution model to identify, evaluate, and select the most appropriate data warehouse, communication mediums, and reporting tools.

**Recommendation 1.4:** Involve risk and compliance representatives when technical and business requirements are developed to ensure technical designs and processes are compliant with all laws regarding sharing and accessing protected information.

#### Why this recommendation?

North Highland heard Coalition Members and stakeholders say they wanted to answer specific types of questions to make meaningful decisions to improve behavioral healthcare. A framework to answer such questions is needed, and the ideal platform to gather transdisciplinary data is a central data repository. Some general questions can be answered with aggregated data, but others impacting individual outcomes, require detailed participant-level data. This central repository model should include a data warehouse that enables the receipt, processing, and storage of identified information and an analytics and reporting tool to surface the data collected.

The Lake County behavioral health community currently has some data sharing in individual silos or point-to-point interactions, but cannot yet answer the systemic level questions desired to be answered. In conjunction with implementing other recommendations (e.g., establishing a data governance board and committees, along with MOUs, data sharing agreements and releases of information), a low-tech pilot project will provide benefits as well as lessons learned, and a foundational starting point to build upon in order to reach the envisioned future state.



# FUTURE DATA SHARING MODEL

## MODEL OVERVIEW

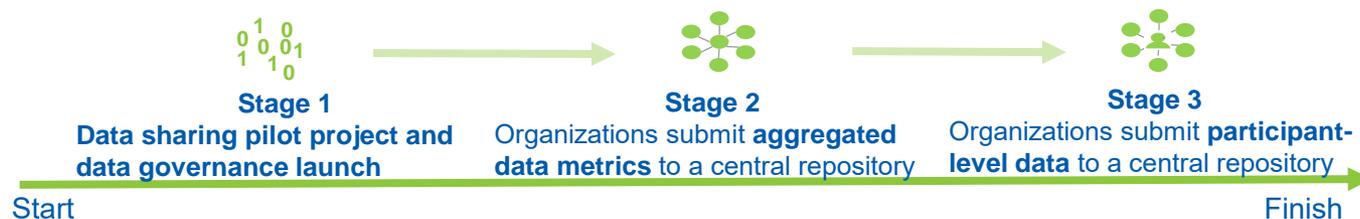
**Recommendation 1:** Implement a staged approach to data sharing that ultimately results in a centralized *data warehouse with participant-level data*. This will enable the collection, analysis, and reporting of both aggregated and participant level data metrics and supports care coordination through look-up capabilities

**Recommendation 1.1:** Begin a staged approach to data sharing by implementing a *Data Sharing Pilot Project* engaging system partners from across-sectors, such as behavioral health providers, emergency departments, Lake County Jail and Lake County Probation. The focus of the Data Sharing Pilot Project would be on simple, low tech solutions to collect a prioritized list of aggregated data metrics.

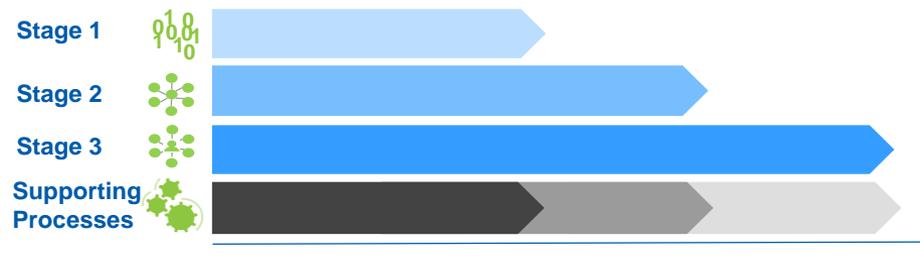
**Recommendation 1.2:** Implement the next stages of the *staged approach to data sharing* advancing more sophisticated ways to collect aggregated data and adding additional organizations to the data initiative, ultimately driving towards a *Data Warehouse with participant-level data*. Implement the next stages based on lessons learned from the Data Sharing Pilot Project.

The following diagram depicts a staged approach for data sharing using three stages. **These stages are milestones by the type of activities and data shared and not by time** as each sector and organization will reach each milestone at a different pace and time based on their respective resources and barriers.

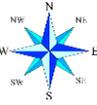
### THE EVOLUTION OF THE DATA SHARING MODEL:



### PROGRESSION OF EVENTS



The work to support, design, and build all three stages starts at the same time. The design elements of future stages are dependent on decisions and work in previous stages.



# FUTURE DATA SHARING MODEL

## EXPLANATION OF STAGES

The below stages and key activities are crucial to recognizing a data warehouse with participant-level information and to enabling improved data-driven decision making during the development of the warehouse.



**Stage 1**  
Data sharing pilot project and data governance launch

- Design a data sharing pilot project engaging early adopters from several cross-system partners
- Design a low-tech solution for collecting aggregated data and preparing reports
- Develop data governance structure including data steward workgroups
- Engage early adopters for data sharing pilot project
- Once designed carry out action plan for pilot project
- Data steward workgroups develop the desired list of data per key decisions /information prioritized
- Build and document definitions for metrics / measurements, standardization processes, and calculations for data metrics and data points to share
- Partner with participating organizations to explore and prepare for data collection and reporting



**Stage 2**  
Organizations submit **aggregated data metrics** to a central repository

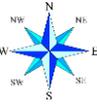
- Submit aggregated data metrics to the central repository
- Identify desired outputs and reporting requirements
- Build a dashboard and reporting practices to display system insights
- Continue to pursue participant-level data sharing needs
- Build a dashboard and reporting practices to display system insights
- Determine range of communications possible given the aggregate nature of the information provided
- Create, review, and sign data sharing agreements across participating organizations and between select organizations as necessary

Data governance activities are required only for the data points that will be shared, not all data points collected by an organization. The amount of work needed to participate in the future data sharing model is therefore partially dependent on the volume of data points shared.



**Stage 3**  
Organizations submit **participant-level data** to a central repository

- Submit participant-level data into a central repository.
- Central repository consists of an MPI (master person index) to match like individuals across organizations
- Identify access and rights per user with participant-level data
- Identify medium for compliant electronic communication
- Create, review, and sign data sharing agreements across organizations and between select organizations as necessary
- Build and maintain release forms



# FUTURE DATA SHARING MODEL

## DATA DRIVEN DECISION MAKING

The staged design to this recommendation enables the participating organizations to have data to inform the answers to organization-specific questions in Stage 1, answers to some system-level questions in Stage 2, and detailed data to answer system-level questions and conduct more robust analysis in Stage 3.

1 0  
0 0 0 1  
1 1 0

### Stage 1 Data sharing pilot project and data governance launch



### Stage 2 Organizations submit **aggregated data metrics** to a central repository



### Stage 3 Organizations submit **participant- level data** to a central repository

- During this stage, organizations can begin to prepare to participate in data sharing efforts.
- Organizations can participate in the data steward workgroups.
- Once the data steward workgroups develop data standardization to support metric calculations, organizations can begin to incorporate needed operations and data collection changes.

The data sharing pilot project supports answering questions such as:

- Who is accessing behavioral health services in community settings and what are their general needs and life functioning abilities?
- How many individuals are accessing behavioral health services in emergency departments? What are their needs? Where are they dispositioned to? How long does that take?
- How many individuals who are booked into jail or on probation have a behavioral health need? Where are they referred for services and how long does it take to access care?

- How many individuals are accessing services?
- What are the demographics (e.g. zip code) of those seeking services?
- What are the behavioral health conditions that individuals/families are seeking services for (e.g. relationship problems, psychosis, depression, suicidal thoughts/actions, substance abuse/dependence, anxiety, etc.)?
- How many behavioral health individuals are accessing services through emergency departments?
- How many behavioral health individuals are being arrested or booked into jail
- Are routine services provided within a pre-determined standard?
- What is the average length of service duration for routine services?
- What is the length of time to access care (by payor, by service)?
- What does the recidivism look like across services within 30/60/90 days?
- What is the current professional per population ratio?
- What is the current bed capacity per population ratio?

- How many unique individuals are accessing services and what are their needs?
- What are the co-occurring conditions for individuals seeking services?
- In the aggregate, what are the overall service intensity needs of the individuals/families (e.g. high, medium, low intensity need)?
- Who are the individuals with the highest needs and are they being served?
- Who is accessing both emergency departments and have they also been arrested?
- What is the recidivism rate per 30/60/90 days by service provider and who are the high utilizers?



# FUTURE DATA SHARING MODEL

## RISK ANALYSIS

The value of sharing data at each stage can improve care coordination on behalf of behavioral health individuals which directly speaks to the Coalition's charter. The risks of data sharing at each stage can be mitigated with data governance and data sharing agreements that address the storage and use of the information.

1 0  
0 0 0 1  
1 1 0

### Stage 1 Data sharing pilot project and data governance launch



### Stage 2 Organizations submit **aggregated data metrics** to a central repository



### Stage 3 Organizations submit **participant- level data** to a central repository

Value

- Begin to recognize the value of improved data internally within organizations
- Enables verbal and informal data sharing of aggregate level information
- Keeps Coalition Members engaged and provides a tangible example of the power of data sharing
- Starts partnerships that can become more profound in later phases

- Answers decisions related to the overall supply and demand of the system
- Enables review at an aggregated level of the services provided
- Speeds up system partners' ability to coordinate care when reporting functionality is available, i.e. waitlist times across behavioral health providers

- Enables the identification of high utilizers
- Enables improved care coordination on behalf of specific individuals
- Enables the identification of intervention opportunities
- Enables care teams to better monitor individuals across services
- Enables higher quality data aggregation
- Enables measurement of outcomes

Risks

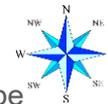
- Organizations having a misperception of the level of effort required for data sharing:
  - Implementation is typically the most demanding and may seem overly daunting
  - Organizations assuming the first milestone is the last and only milestone and thus not devoting the appropriate resources
- Costs for new fields or product builds
- Internal red tape to collecting new data or creating new fields
- Operational costs of the changes required to improve manual data entry to enhance data quality

- Difficult to normalize aggregated data across organizations into a single data point
- Can link together the information as provided by organizations, but difficult to make a calculation from pre-calculated metrics without the underlying components and/or predetermined and agreed upon assumptions
- High-level dimensions may be deduced via analysis to underlying data dimension components but the assumptions made in doing so may be inaccurate

- Data access, storage, and communication need to be compliant and the consequences of non-compliance are high.
- The ability to analyze data in a larger variety of methods means that more data governance is needed.
- Increased risk and compliance oversight is required
- As new organizations enter into the data sharing model, there is an opportunity for disruption

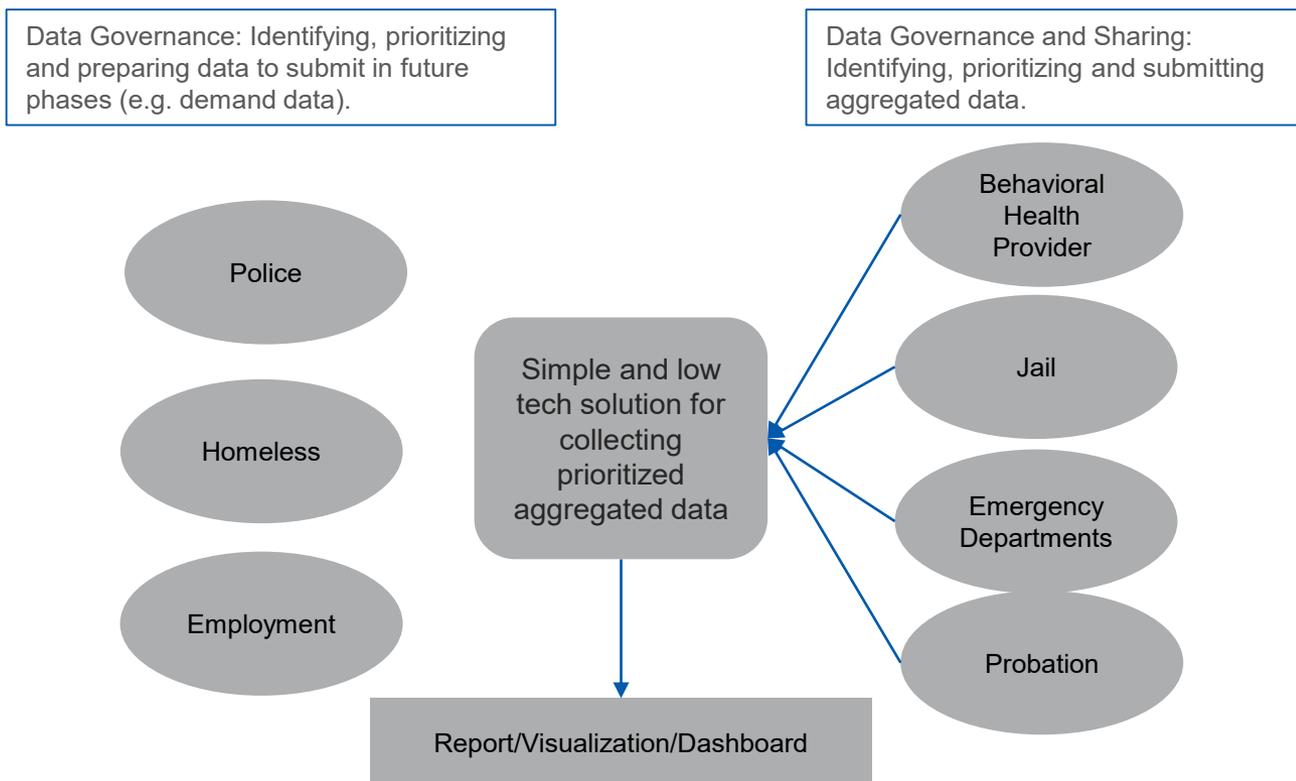
# FUTURE DATA SHARING MODEL

## PILOT PROJECT DATA SHARING APPROACH



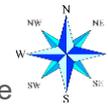
A pilot project is envisioned to afford the Coalition an opportunity to test initial data collection and reporting strategies that can then be used to inform a future, larger-scale data sharing plan. Further, a pilot project supports the **initial collection of some crucial information that can be used for planning and oversight purposes**. A Data Sharing Pilot Project engages early adopters from several cross-system partners to submit aggregated data including behavioral health providers, emergency departments, Lake County Jail and Probation while other system partners are working to identify behavioral health data (e.g. demand data) to submit in future stages.

The below illustrates that organizations can start preparing to share data by identifying, evaluating, and standardizing information across systems while other organizations can be sharing aggregated data to test early wins and the data that is most impactful for decision making. Not all system adopters are presented below and early adopters have yet to be determined.



# MODEL TECHNOLOGY SUPPORT

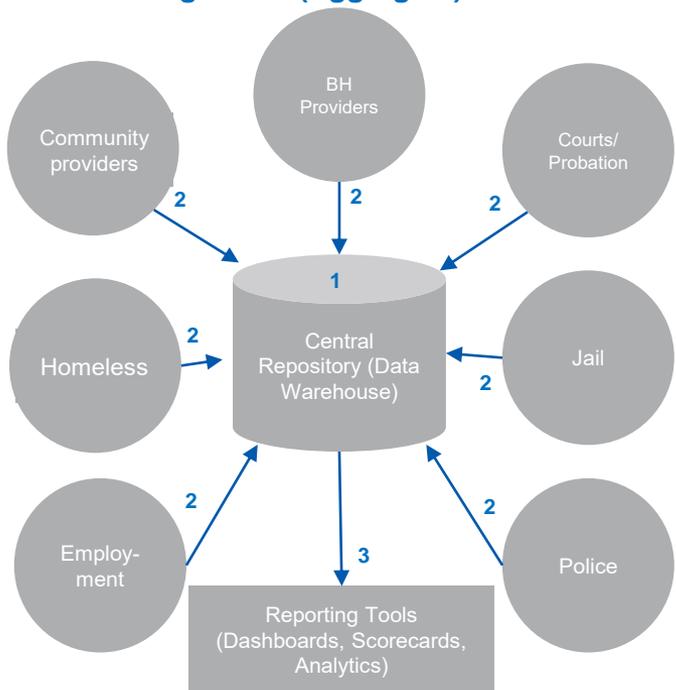
## AGGREGATED DATA METRICS CENTRAL REPOSITORY TECHNOLOGY



**Recommendation 1.3:** Detail the business requirements for the overall solution model to identify, evaluate, and select the most appropriate data warehouse, communication mediums, and reporting tools. .

There are a variety of ways the data sharing of aggregated data can be supported from a technology standpoint. Below are examples of some of the products and technology demands and characteristics for a central repository / data warehouse, data transfer, and reporting tools. The exact demands and characteristics required are fleshed out during the data implementation plan phase as a part of the business requirements and detailed design of the overall solution.

### Data Sharing Model (Aggregate)



### Technology Considerations

#### 1. Central Repository / Data Warehouse

When selecting technology for the development of **Stage 2**, it is important to select a solution that can also be leveraged for **Stage 3**. One of the initial technical considerations and decisions will be the type of Central Repository (Data Warehouse) that will best meet the needs for both Aggregated Data (Stage 2) as well as Participant Data (Stage 3). Data Warehouse solutions typically consist of a relational database platform which can either be located on-site within the organization or in a cloud environment. The following are examples of vendors that could potentially serve as the Central Repository (Data Warehouse): Microsoft SQL Server, Oracle Data Warehouse and Oracle Exadata, IBM Data Warehouse, SAS Data Warehouse, etc. These vendors provide both on-premise solutions as well as cloud-based solutions.

#### 2. Data Transfer

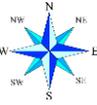
Identifying the technology approach to transfer data from each of the source locations and systems is essential. Each source system may require a unique approach for extracting and transferring data to the Data Warehouse. The process typically consists of developing some type of “Export” out of the source systems (Police, Jail, Courts/Probation, etc.), securely transferring that data to the Data Warehouse, and then the Data Warehouse reconciling (MPI) and importing the information so that it can be used for analytical purposes. Some options for transferring data include: ADT messaging, HL7 messaging, USB drop off, access database, excel spreadsheets, secure connection programs, etc. See next page for recommendations for securely transferring data.

#### 3. Reporting Tools

To allow access to the rich set of new information that now resides in the Data Warehouse, a number of technology options exist to report out the data. To support the different types of Data Warehouse approaches, the reporting solutions can access data within a Data Warehouse which is on site. Solutions are often web-based and mobile friendly. Advanced analytics tools are also available to provide predictive analytics capabilities. Some potential tool options include: Microsoft Power BI, Tableau, QlikView, SAP Business Objects, IBM Cognos, and many others. Predictive analytics tools include SAS, R, Oracle Data Mining, IBM Predictive Analytics, etc.

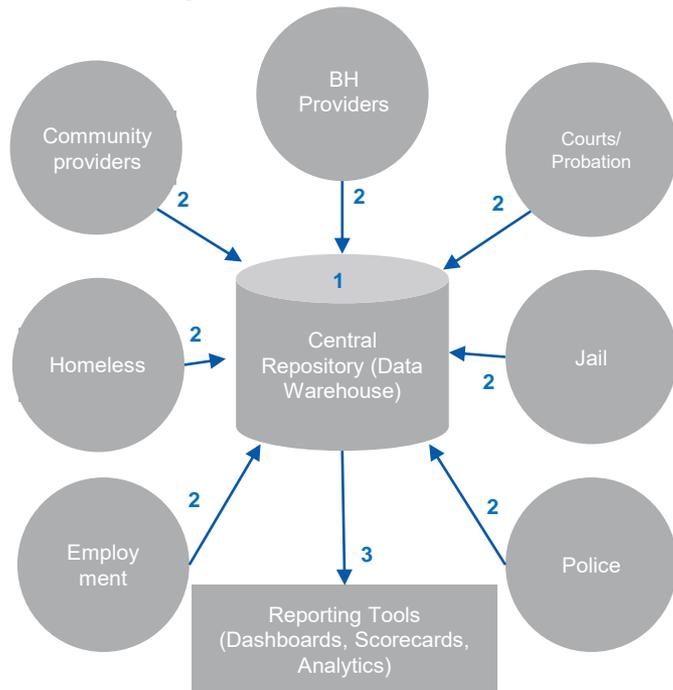
# MODEL TECHNOLOGY SUPPORT

## PARTICIPANT-LEVEL DATA METRICS CENTRAL REPOSITORY TECHNOLOGY



Supporting participant-level data sharing requires additional programming as the information and the programs that store the data must meet the requirements of the various sectors included, such as HITECH for healthcare data. Below are other considerations and recommendations for sharing, storing and using data. The exact method and medium will be decided upon during the data implementation plan phase as a part of the business requirements identification process and will depend on the parties involved. Limited data sets with participant-level information should be shared in Stage 3 and therefore organizations' risk and compliance counsel should be included in the data governance workgroups and during the development of business requirements for Stage 3.

### Data Sharing Model (Participant)



### Technology Considerations

#### 1) Merging / Integrating Data into the Data Warehouse

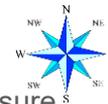
As mentioned on the previous page, the same technologies can be used for both Aggregate and Participant data. Individual / Participant Matching or MPI Process is critically important when collecting participant-level data from different entities and data sources. This process, which should be well defined and designed, bought or built, ideally should be in place as participant-level data is brought into the data warehouse. Without it, the data warehouse will not have the ability to integrate one individual's data from different sources (e.g., hospital and jail).

#### 2) Securely Transferring Data from Sources to Data Warehouse

Security considerations are heightened when transferring “participant data” from the source location to the Data Warehouse. “In Transit” security will ensure data is secure when it is being transmitted from the source organization to the centralized Data Warehouse. One option for “In Transit” security is to use a security protocol, such as SSL (Secure Sockets Layer) or TLS (Transport Layer Security) when moving data from one location to another. This approach means data is encrypted before being transmitted out of the source system and then it is unencrypted once it arrives at that destination location, which is the Data Warehouse. In addition to leveraging a security protocol, organizations can also use a VPN (Virtual Private Network) to isolate the communication channel between the source system and the Data Warehouse location.

### 3. Reporting Tools

Several considerations have to be taken when selecting reporting tools. One critical area to be considered is ensuring security is well established. “At Rest” security measures are applied at the database level to ensure only those individuals who need to access the data are the ones who can actually access the data via the reporting tools. Other considerations for reporting tools include: Adhoc reporting, fixed reports vs. drop-down enabled reports, web-enabled, mobile accessible, self-serve reporting (where business can build their own reports), etc..



# MODEL COMPLIANCE

**Recommendation 1.4:** Involve risk and compliance representatives when technical and business requirements are developed to ensure technical designs and processes are compliant with all laws regarding sharing and accessing protected information.

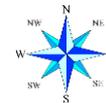
Each state of the data sharing initiative will have different legal considerations to address. During the Stage1 and Stage 2, changes required to collect, calculate or standardize data to be shared would only need to be compliant with participating organizations' internal policies. With participant-level data and limited data sets in Stage 3, additional safeguards must be met and outlined to adhere to federal and state laws pertaining to protected information. Involving risk and compliance representatives will be essential during design phases. Below is a description of legal considerations per stage.

## Stage 1 - Preparing to Share Data

- Participating organizations need to determine whether the collection, storage and standardization of data points is compliant with their internal policies.
- If an organization needs to begin to capture new data or follow new data collection practices, those changes may warrant review by its legal counsel should there be a legal concern surrounding the ability to store a new type of data.
- Define data standards and practices, such as the data points to use, how to calculate data metrics, and how to aggregate those metrics.
- During Stage 1, risk and compliance policy advisors from organizations that are held to similar laws, such as healthcare providers, should have input on how and what data is allowable.

## Stage 2 - Aggregated Data Metrics Central Repository

- Aggregated data metrics do not include data to identify an individual and therefore is not protected by the same laws as participant-level information.
- The data metrics can be legally shared if the factors involved in the data sharing initiative meet the requirements of the data owners.
- The data owners, which are most often the participating organizations, are the primary drivers for the policies and practices of sharing data. It is important to note that an organization's operational ability to share data differs from the legal ability, but both can be incorporated into data sharing policies.
- The detailed legal requirements for these policies are surfaced during the business requirements investigation phase and inform the baseline requirements for the data warehouse and the data sharing agreement to be signed by the participating organizations.
- Organizations legal and policy teams should continue to meet during this stage to oversee the sharing, storage, and use of the shared aggregated metrics to maintain the data sharing and adjust agreements as need be.

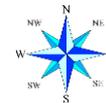


# MODEL COMPLIANCE

## Stage 3 - Participant-level Data Metrics Central Repository

Below are some key recommendations for risk and compliance counsels to consider when providing input on the required functionality to be compliant with laws that protect personal identifiable information, such as HIPAA, 42 CFR, and 740 ILCS 110. The details behind each organization's privacy policies and practices will surface during the business requirements identification process and will help to shape the detailed characteristics and functionality of the data sharing model.

- Design controls to access to information:
  - Some of the service capacity data metrics, such as available beds, in Stage 2 will continue to be shared through Stage 3 as participant-level information can not be aggregated to arrive at the same metrics. Legal and policy advisors may then choose to have multiple views into the data sharing model from the analytics and reporting tool: one for all users, one for all users without health information, one for all users with health information.
  - For when personally identifiable information is accessed, technology should be installed which requires users to confirm they have a valid reason to access and view participants' information. Employees, within a HIPAA covered entity, typically are required to confirm and verify, sometimes twice, that they have legitimate reasons to access a patient's records. Generally, implementations use pop-up windows to provide a challenge "verification needed" question to the user – an effective way to raise the attention of the user but yet provide a quick way to provide confirmation and proceed to view and using the necessary patient data.
  - Organizations serving members covered by Substance Abuse and Confidentiality: 42 CFR Part 2 may choose to have an indicator within its systems or a filtering program to identify these individuals as having protected information. This indicator can act as an additional layer of control and protection when filtering, cleaning and sharing data to ensure that the information is excluded or that the correct releases are in place.
- Establish training
  - Training should be developed by access right groups so that users know how to access and use information according to the sharing agreements and laws surrounding the model. HIPAA covered professionals are required to go through training to ensure on-going compliance with data standards. This training can be generic and users of the program should verify that they have completed their organization's training prior to using the program.
- Implement policies and procedures that can help ensure compliance
  - Employing strict accountability and severe penalties will help ensure user compliance when accessing, sharing, and using participant-level information.
  - Purchasing HITECH certified software to store and manage the data will help ensure the security of the information stored.
  - Conducting internal audits of data access and usage across several dimensions, such as users and data type, will help in the early detection of potential issues and ensure users' compliance



## NORTH HIGHLAND RECOMMENDATIONS

### DATA GOVERNANCE STRUCTURES AND PROCESSES

**Recommendation 2:** *Implement Data Governance Structures, Standard Operating Procedures, Security, and Processes* to support sustainable success of data sharing.

[Recommendation 2.1:](#) Develop Data Governance structures inclusive of Steering Committee, Data Stewards and Data Custodians.

[Recommendation 2.2:](#) Create the Data Steward Working Groups organized around subject areas.

[Recommendation 2.3:](#) Mobilize the Data Steward Working Groups to prioritize and standardize data for collection, initially focusing on data for the Data Sharing Pilot Project.

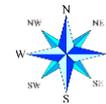
[Recommendation 2.4:](#) Implement data sharing agreements across system partners that address necessary terms of data sharing while utilizing processes that foster trust enabling system partners' willingness to participate.

[Recommendation 2.5:](#) Develop and execute Memorandum of Understandings (MOUs) for all Lake County behavioral health community stakeholders who are willing to commit their efforts toward a data sharing initiative.

[Recommendation 2.6:](#) Develop a universal Consent to Release Information form that addresses the requirements of federal and state laws that enable organizations to share data for individuals who provide consent.

#### **Why this recommendation?**

Industry best practices regarding data sharing state that, in order to be successful, data governance must be established and address governance related to people, process, and technology. All potential participants in any data sharing project need to feel comfortable with the framework through which information will be shared, the rules for sharing information, and the benefits that will be realized from such sharing..

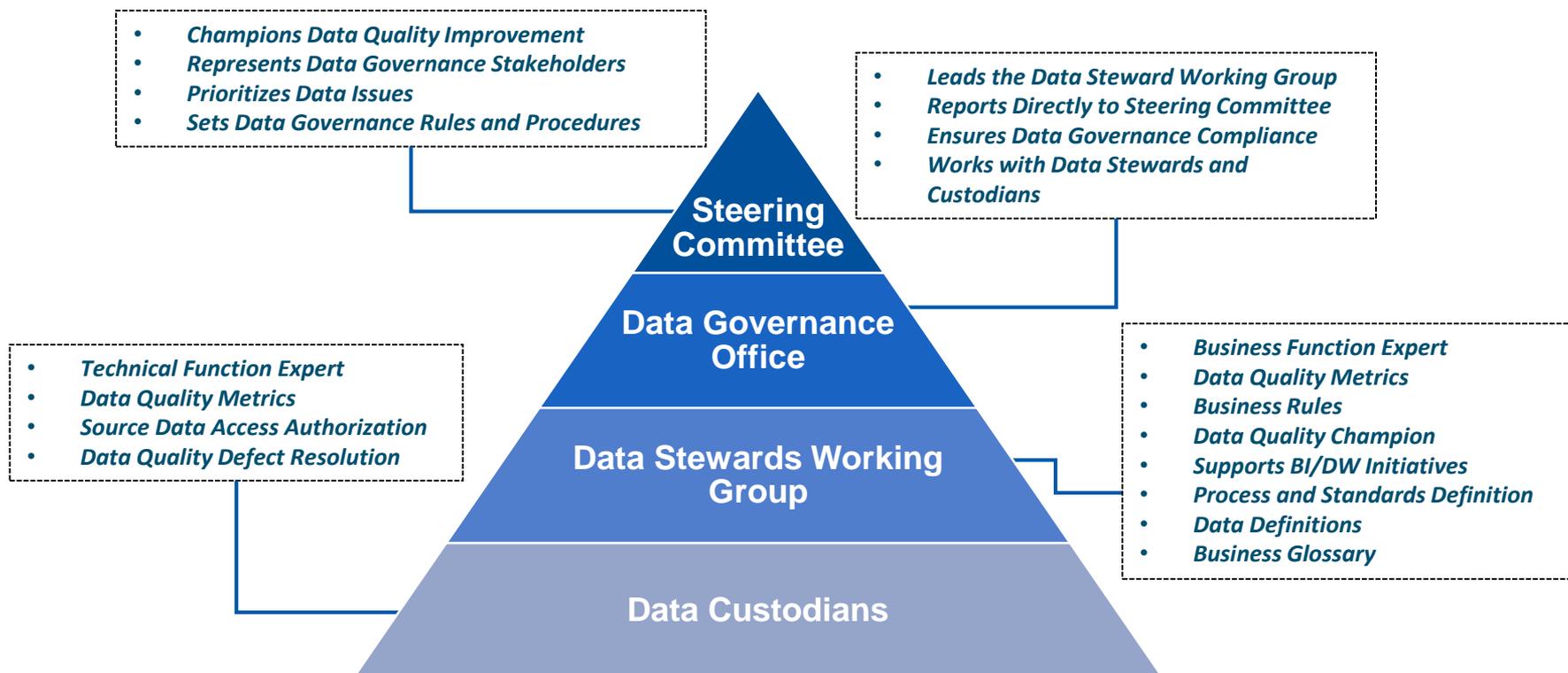


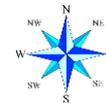
# DATA GOVERNANCE STRUCTURE

**Recommendation 2.1:** Develop Data Governance structures inclusive of Steering Committee, Data Stewards, and Data Custodians.

## Background:

Data governance involves decision-making, management, and accountability related to the data in an organization, or in the case of the future data sharing initiative, a system of organizations. Often, a data governance structure is built to ensure data will be handled smoothly and effectively and to instill data quality. Data governance programs are designed to prepare rules and regulations for an organization and to handle any issues that may arise regarding data. Data governance structures also ensure compliance with policies. The most crucial step is establishing a data governance structure as it is the foundation for data governance success. A sound data governance structure and program includes a governing body or Steering Committee, a defined set of procedures, and a plan to execute those procedures. Additionally, data stewards and teams are tasked with ensuring that data and metrics are defined and handled smoothly and effectively.





# DATA GOVERNANCE STRUCTURE

## SUBJECT AREA DATA STEWARDSHIP

**Recommendation 2.2:** Create the Data Steward Working Groups organized around subject areas.

### Background:

The Subject Area Model for data stewardship work groups is recommended because similar data needs to be combined from many different entities and disparate systems across the participating organizations which requires in-depth knowledge of system capabilities and the data definitions and rules per type of data set. Therefore the data should be brought in, integrated, and normalized along key subject areas.

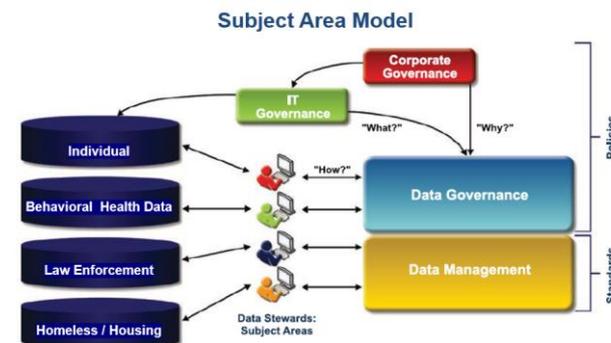
- The Coalition will be best served to have data stewards across organizations who have the knowledge and expertise to provide standards and definitions in each of the subject areas.
- To support Stage 3, in which organizations share participant-level information into a central repository, a risk and compliance subject area data steward work group should be developed. This work group should be established at the beginning of the future data sharing initiative, as coming to an agreement on how to share and store limited data sets can take a long time and the process of coming to an agreement can inform the business requirements of the system.

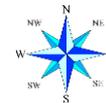
### The benefits of a data subject area oriented stewardship model include:

- Ownership boundaries that are usually clear.
- The data steward's knowledge of the accompanying business rules and usage environments for his/her data subject area are likely to increase over time.
- This model is often easy to understand and explain, thus reduce resistance during implementation.

### The risks of data subject area stewardship include:

- The potential size and scope of a given data domain – across multiple stakeholder organizations, processes, and data sources – may make finding qualified data stewards challenging.
- Subject area data stewardship can be territorial, especially if system owners refuse to cede control.





# DATA GOVERNANCE STRUCTURE

## SUBJECT AREA DATA STEWARDSHIP

### Background cont.

The Coalition and the Lake County behavioral health community should assemble data steward working groups from across organizations that have either functional or technical expertise pertaining to the data being shared. Data standardization, the technology to share data, and the use of the data are projected to be complex challenges given the disparate systems and high volume of organizations interested in data sharing.

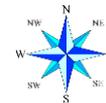
A subject area is defined as a group classification of business data entities at its highest level of data object abstraction.

Subject areas can be both functional and technical. The functional will focus on semantic definitions for a given subject area. There may be other data areas, such as the raw EMR data, that may require a group of people, with representatives from different EMR systems, to focus on what and how data elements from different EMRs will be integrated. Proactively discussing the functional and technical business requirements of the future data sharing model will assist in designing the resulting data warehouse and assist the functional data stewards and business analysts with what data will be made available through the reporting tool.

The future data sharing model will collect and integrate data from many different organizations and functional data steward work groups will need to focus on defining the common “master data” for the future data sharing model. For example, with individual or patient data, data steward working groups will address questions such as “how does the Coalition want to define an individual/patient and what data elements/attributes are to be collected?”. Data steward workgroups should partner with the participating organizations to understand it’s definition and highlight for those organizations how it’s definitions differ from the definitions agreed upon for the future data sharing model.

In addition to definitions, attributes, metrics, and calculations, data steward work groups will need to establish rules for integrating data from the different organizations such that the data is normalized. The data stewards assigned to the subject areas are responsible for defining and documenting the definitions and rules so that the rules are clear to all contributors and consumers of the data.

Often times, technical subject areas consist of information-related or metadata-related accountabilities that focus on master data, such as patients or individuals, services, locations, organizational hierarchies, etc. Master data represents the business objects which are agreed on and shared across a given enterprise or interrelated organizations. It can cover relatively static reference data, transactional, unstructured, analytical, hierarchical and metadata.



# DATA GOVERNANCE STRUCTURE

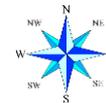
## SUBJECT AREAS FOR CONSIDERATION

The data governance organization and data stewards will need to agree to and confirm the data to be collected by the data warehouse and subsequently, the initial data subject areas to focus on. There will more than likely be an initial list of subject areas, with the list evolving over time as data is added and as the Coalition and Lake County behavioral health community matures in its data sharing and consumption. Below is an initial list for the Data Governance Organization which organized by the three sectors.

Additionally, two key subject areas, which span across-sectors, are listed below:

- 1) Individual / Participant Master Data – this group will be key to determine the methods and rules for matching records for an individual / participant across the different organizations and systems
- 2) Data Security, Risk, and Compliance – this group should set the policies and procedures to share secure data as well as actions to be taken when lapses occur in handling sensitive data

Healthcare	Judicial	Community
<p><u>Functional</u></p> <ul style="list-style-type: none"> <li>• Emergency dept. process data</li> <li>• Inpatient process data</li> <li>• Patient physical health data</li> <li>• Patient behavioral data</li> <li>• Provider data</li> <li>• Payor &amp; MCOs data</li> </ul> <p><u>Technical</u></p> <ul style="list-style-type: none"> <li>• EMR data</li> <li>• Encounter / claims data</li> </ul>	<ul style="list-style-type: none"> <li>• 911 Dispatch</li> <li>• Law enforcement</li> <li>• Jail</li> <li>• Court</li> <li>• Probation</li> </ul>	<ul style="list-style-type: none"> <li>• Housing</li> <li>• Referrals</li> <li>• Additional Services</li> </ul>
Individual / Participant Master Data Management / MPI		
Data Security, Risk, & Compliance		

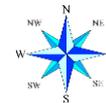


# DATA GOVERNANCE STRUCTURE

## NEXT STEPS

Data governance is complicated and can be time consuming. Data governance should begin as soon as possible and below are the recommended data governance starting points and activities based on the needs of the future data sharing model.

	Stage 1 - Preparing to Share Data	Stage 2 – Aggregate Data Metrics	Stage 3 – Participant-Level Data
People	<ul style="list-style-type: none"> <li>Establish data governance steering committee</li> <li>Begin to identify and establish Data Steward Working Group(s)</li> <li>Assess and build staffing plan for data sharing solution and hire or obtain necessary staff for Stage 2 efforts</li> </ul>	<ul style="list-style-type: none"> <li>Maintain data steward working group(s) and add a level of complexity to discuss Stage 3 needs given the different data</li> <li>Determine data custodians</li> <li>Hire or obtain necessary resources for Stage 3 efforts</li> <li>Establish data steward working groups for Individuals / patient master data management</li> </ul>	<ul style="list-style-type: none"> <li>Transition Data Stewards as needed from implementation to sustainability and maintenance</li> <li>Test staffing plan assumptions and needs through trials</li> </ul>
Process	<ul style="list-style-type: none"> <li>Educate participating organizations on the value of data governance and the roles and responsibilities of data governance committees.</li> <li>Establish and conduct Steering Committee meetings</li> <li>Begin to establish policies &amp; procedures for Data Governance</li> <li>Select a data steward framework</li> <li>Determine and agree to initial scope of data sharing</li> <li>Identify initial subject areas of focus</li> <li>Work to set scope and requirements (metric definitions / calculations, reporting requirements) for Stage 2</li> </ul>	<ul style="list-style-type: none"> <li>Define / design technical process for data intake for Stage 2 and identify considerations for Stage 3</li> <li>Determine method for conducting Master Individual / Patient matching</li> <li>Identify facts (Measures) and dimensions. Dimensions define the different options to search the aggregated data.</li> <li>Consider appropriate facts and dimensions that can be used in both Stage 2 and Stage 3.</li> <li>Identify security roles for Stage 2 aggregate data metrics.</li> <li>Begin considerations for security roles for Stage 3 participant-level data.</li> </ul>	<ul style="list-style-type: none"> <li>Refine technical process for data intake for Stage 3</li> <li>Refine Fact and Dimensions as needed to handle Participant-Level Data</li> <li>Manage new entrants and systems connections</li> <li>Document implementation process and conclusion and maintain SOP documentation</li> <li>Establish change request process and guidelines</li> </ul>
Technology	<ul style="list-style-type: none"> <li>Determine and agree to future data sharing model</li> <li>Begin to plan for infrastructure for Stage 2 Solution</li> <li>Begin reviewing design architecture considerations for Stage 2 &amp; 3 solution</li> </ul>	<ul style="list-style-type: none"> <li>Refine design architecture of Stage 3 solution</li> <li>For Stage 2 &amp; 3, begin to assess and make “buy” versus “build” decision</li> <li>Obtain necessary infrastructure (database, intake tools, reporting tools) for Stage 2 &amp; 3</li> <li>If decision is to “buy”, execute an RFP and selection process for technology</li> <li>Develop solutions to extract data from sources, load in the data warehouse, and build reports</li> </ul>	<ul style="list-style-type: none"> <li>Manage change requests</li> <li>Evaluate performance of existing infrastructure</li> <li>Develop solutions to extract data from sources, load the data warehouse, and build participant-level reports.</li> </ul>



## DATA RECOMMENDED FOR MODEL

[Recommendation 2.3:](#) Mobilize the Data Steward Working Groups to prioritize and standardize data for collection, initially focusing on data for the Data Sharing Pilot Project

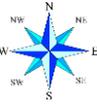
During the August and September meetings, Coalition Members and stakeholders identified the questions of greatest importance and the data points that could help address those questions given two primary tools: a System Questions to Answering Key Questions and a Data Matrix. The Data Matrix highlighted how data measurements can be reached with existing or new data points and/or agreements and protocols. The Data Matrix included whether that data point was available at the participant or aggregate level based on the information provided during the Current State Assessment interviews. The list of possible data points does not verify that it is possible or easy to share the data points included, it is simply a tool to surface and raise awareness of the data that would be most impactful for decision making.

The purpose of providing this matrix at Workshop 1 was to brainstorm data that could be used to support key decisions. Given the key questions that the group prioritized during the discussions in Workshop 1, this list was then condensed into a second Data Matrix. This condensed Data Matrix helped to narrow the focus of what data points could provide insights to answer Coalition Members and Lake County behavioral community members' key questions.

The following grids illustrate the recommended data standardization next steps required to recognize the future data sharing model. These enhancements are the recommended activities to support the data collection, standardization, and quality across system partners so that the desired data can be shared at a later date. The data steward workgroups should be charged with using this list of data points to begin discussions on the availability and accessibility of desired data points to arrive at an agreed upon list of data points to share both during the pilot and in Stage 2 and Stage 3 of the future data sharing model.

Details behind the data point storage and accessibility are surfaced during the development of an implementation plan which outlines the required steps to collect, access and calculate the data.

# DATA RECOMMENDED FOR MODEL HEALTHCARE ORGANIZATIONS



The following grid outlines the data governance activities required by sector to share the data points in Stage 2 and 3 that can help answer the prioritized questions. It is recommended that sector representatives and the data governance committee review these data points for availability and accessibility within each organization to identify the ability to share this information and the detailed steps to do so. It is important to note that each organization will reach each stage at different times depending on their ability to overcome their unique technical and operational barriers.

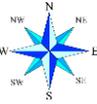
Next to each data metric or data set is an indicator of the key question that the data metric and participant-level information can help answer.

**Legend:**

- Who is in need of or seeking behavioral healthcare?
- Are the service needs of those accessing behavioral care being met?
- Are the services provided impacting outcomes and making a difference for individuals and families served?

Service Provider	Preparing to Share Data		Data Sharing	
	Stage 1- Preparing to Share Data	Stage 2 – Aggregate Metrics	Stage 3 – Participant-Level Data	
 Behavioral Health Providers	<ul style="list-style-type: none"> <li>Work with data steward workgroups to share the types of information currently collected</li> <li>Explore options for how new data points could be collected within their organization.</li> <li>Identify within their organization where and who has the potential data points identified by the stakeholders as priority data</li> <li>Explore and understand how to access data points that maybe on the back end of systems vs. forward facing (e.g. time stamp capabilities).</li> </ul>	<ul style="list-style-type: none"> <li>Functioning Scores</li> <li>Total by Diagnosis</li> <li>Total Problem Codes</li> <li>Average Length of Stay by diagnosis</li> <li>Total Demographic information</li> <li>Total of patients seen across service lines</li> </ul>	<ul style="list-style-type: none"> <li>Claims Data</li> <li>Serviced patients within a timeframe (frequency of occurrence can inform recidivism)</li> </ul>	
ED	<ul style="list-style-type: none"> <li>Investigate what data is captured or could be captured based on the prioritized key decisions/information and data points prioritized by the stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>Total accessing ED for BH needs (by payor)</li> <li>Demographics</li> <li>Referral source</li> <li>Disposition</li> </ul>	<ul style="list-style-type: none"> <li>Claims Data</li> <li>Serviced patients within a timeframe (frequency of occurrence can inform recidivism)</li> </ul>	
Inpatient	<ul style="list-style-type: none"> <li>Investigate how to measure timeliness of access to service</li> </ul>	<ul style="list-style-type: none"> <li>Total of individuals accessing service</li> <li>Capacity timeliness of access to service</li> </ul>	<ul style="list-style-type: none"> <li>Claims Data</li> <li>Serviced patients within a timeframe (frequency of occurrence can inform recidivism)</li> </ul>	

# DATA RECOMMENDED FOR MODEL JUSTICE SYSTEM



## Preparing to Share Data

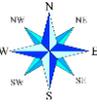
## Data Sharing

Service Provider	Stage 1- Preparing to Share Data	Stage 2 – Aggregate Metrics	Stage 3 – Participant-Level Data
 Police	<ul style="list-style-type: none"> <li>• Explore ways to partner with 911 consolidation project</li> <li>• Prioritize data points needed for understanding prevalence of behavioral health needs and coordinating with the 911 consolidation project, such as creating a universal flag within the dispatch systems for CIT officer needed or behavioral health need</li> <li>• Determine a feasible location for electronic form for CIT assessment</li> <li>• Create a field to capture the number of CIT calls per address</li> <li>• Understand the needed access to metadata for time-stamped information</li> <li>• Build standardized fields to document drop off location (as opposed to free text and notes)</li> </ul>	<ul style="list-style-type: none"> <li>● Dispatch: Number of individuals with calls into 911 with behavioral health need</li> <li>● Dispatch: Number of calls into 911 with an officer dispatch for a behavioral health need</li> <li>● Total by behavioral health drop off locations</li> <li>● Number of sworn officers who have completed CIT training</li> <li>● Number of other law enforcement personnel to complete CIT training</li> </ul>	<ul style="list-style-type: none"> <li>● Behavioral health encounters per individual</li> </ul>
Jail	<ul style="list-style-type: none"> <li>• Explore options for automated data loads of key information from court and probation screenings into the jail healthcare EMR</li> <li>• Explore implementing a physical health and behavioral health screen</li> <li>• Ensure the behavioral health population identifier is consistent with behavior health providers</li> <li>• Begin to explore ways to electronically share booking information with providers on a daily basis</li> <li>• Enhance opportunities to partner with organizations outside of the jail to coordinate transition out of jail for individuals with behavioral health needs</li> </ul>	<ul style="list-style-type: none"> <li>● Total individuals with behavioral health needs in jail</li> <li>● Total of those behavior health individuals that recidivate</li> <li>● Total individuals assigned to specialty courts</li> </ul>	<ul style="list-style-type: none"> <li>● Claims</li> <li>● Inmate services received over a period of time</li> </ul>

**Legend:**

- Who is in need of or seeking behavioral healthcare?
- Are the service needs of those accessing behavioral care being met?
- Are the services provided impacting outcomes and making a difference for individuals and families served?

# DATA RECOMMENDED FOR MODEL JUSTICE SYSTEM



## Preparing to Share Data

## Data Sharing

### Stage 1- Preparing to Share Data

### Stage 2 – Aggregate Metrics

### Stage 3 – Participant-Level Data

Service Provider



Courts

- Build field to flag individuals as having been to Mental Health Court before
- Explore capturing information about identified behavioral health needs that were identified by Probations

- Total number of screens conducted within court (supports trend analysis)
- Total number of individuals within Mental Health Courts
- Individuals within Mental Health Court (Recidivism)
- Individuals screened (early detection)

Probation

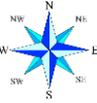
- Create unique fields to document payor, care coordination attempts, and the result

- Total number of records in the probation data system that have the behavioral health flag checked
- Total patients currently waiting for services by service and payor
- Demographic and progress information for probationers with behavioral health needs. (to help with automated address updates and probationer tracking, and notifications of appointment adherence)

**Legend:**

- Who is in need of or seeking behavioral healthcare?
- Are the service needs of those accessing behavioral care being met?
- Are the services provided impacting outcomes and making a difference for individuals and families served?

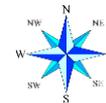
# DATA RECOMMENDED FOR MODEL COMMUNITY ORGANIZATIONS



Service Provider	Preparing to Share Data	Data Sharing	
	Stage 1- Preparing to Share Data, Data Point Enhancements	Stage 2 – Aggregate Metrics	Stage 3 – Participant-Level Data
 Homelessness	<ul style="list-style-type: none"> <li>Outline needed fields within Service Point to capture behavioral health information</li> <li>Convert Excel data when possible to Service Point</li> <li>Work with other sector organizations to identify ways to capture homelessness- i.e. lack of address provided in a hospital, integrating new questions into other organizations intake forms</li> </ul>	<ul style="list-style-type: none"> <li>Total of behavioral health specialists on staff</li> <li>Total individuals seeking housing with behavioral health needs</li> </ul>	<ul style="list-style-type: none"> <li>Individuals seeking housing with behavioral health needs</li> </ul>
Workforce	<ul style="list-style-type: none"> <li>Explore ways to capture behavioral health information</li> </ul>	<ul style="list-style-type: none"> <li>Total individuals with behavioral health needs seeking jobs</li> <li>Total jobs available that could support an individual with behavioral health needs</li> </ul>	<ul style="list-style-type: none"> <li>Unique individuals with behavioral health needs seeking employment services</li> <li>Duration of employment per individual with behavioral health needs</li> </ul>

**Legend:**

- Who is in need of or seeking behavioral healthcare?
- Are the service needs of those accessing behavioral care being met?
- Are the services provided impacting outcomes and making a difference for individuals and families served?



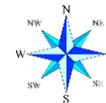
# DATA SHARING AGREEMENTS

**Recommendation 2.4:** Implement data sharing agreements across system partners that address necessary terms of data sharing while utilizing processes that foster trust enabling system partners' willingness to participate.

"The speed of trust" is a phrase used within change and data sharing literature to describe the pace at which a change and/or the sharing of data will move. Building trust is critical and the following strategies are recommended to support the development, and ultimate signing of, data sharing agreements across stakeholders and enable a data sharing initiative.

- **Stakeholder Engagement:** The appropriate stakeholders need to be engaged in order to sign a legally binding document. Legal and compliance advisors and business leaders from participating entities need to be informed along the way and have an opportunity to provide input for cross-sector data sharing agreements to be in place. This often takes the form of a committee that adapts over time to address the participating organizations' changing priorities for the data sharing program. It is critical that the data governance committee work side by side with the legal advisory counsel so that recommendations are approved by a neutral and balanced committee representing the diverse stakeholders invested in the data sharing project. This involvement and back and forth takes time but is critical to reaching an agreement across stakeholders.
- **Education:** Data governance and legal committees need to address the key sponsors of change within their own organizations to garner internal support for cross-organizational data sharing. This is most successful by educating individuals on the impacts of data sharing with a clear vision and value proposition tailored to each organization. To this end, Data Governance and risk and compliance committees should leverage the "What's in it for me" messaging identified in the current assessment of data sharing to develop organization-specific value propositions. The value proposition should communicate early wins from sharing data within the community to provide a tangible example of how data sharing can improve individual outcomes and bring value to the participating organization.
- **Start Small:** Start with effective, small steps to immediately prove the value of data sharing. These steps include identifying and executing small data sharing opportunities that can yield high results directly related to the goal of the participating organization and the objective of future data sharing model. The activities and resources required to start with small opportunities should not conflict with the resources needed to develop and recognize the future data sharing model.

When looking for data sharing opportunities, leverage previous data sharing relationships as data sharing practices that have been agreed to previously offer a stronger starting point without having to "recreate the wheel." In Lake County, this will likely be leveraging agreements that were put in place for former or current grant initiatives.



# DATA SHARING AGREEMENTS

- **Use agreements to organization's advantage:** Add language in the agreements to address specific organization's concerns to ensure trust amongst its participating organizations. This trust may also drive the design of the future data sharing model and the data governance structures required to sustain data sharing.

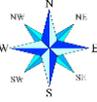
Data ownership is a big concern within the Lake County behavioral health community and making sure that participant's concerns, such as ownership, are spelled out in agreements will be particularly effective in building trust. For instance, "who will own the data?" is a frequent question during data sharing conversations. During workshops, Coalition Members and stakeholders voiced enthusiasm over the Nursewise model, in part because it was a third party organization that directed care to the right place and right time, aggregated data, and served organizations across sectors, and it reported out key data metrics on behalf of the region it served. It will be critical for Lake County organizations' to buy into the data sharing model to define the ownership of the data stored in the central repository and the distribution and allowed the use of the analytics and reporting output.

In order for Lake County organizations to buy into the data sharing model and to encourage trust amongst participants, it will be critical to define the ownership of the data stored in the central repository, as well as the distribution and allowed the use of the analytics and reporting output.

Non-compete agreements should also be considered as part of the data sharing agreements for organizations that believe in the value of data sharing but have concerns about sharing data with its competitors. Non-compete clauses allow organizations to feel protected against competitive harm and the misuse of the information provided.

# DATA SHARING AGREEMENTS

## MEMORANDUM OF UNDERSTANDING

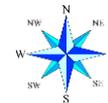


[Recommendation 2.5:](#) Develop and execute Memorandum of Understandings (MOUs) for all Lake County behavioral health community stakeholders who are willing to commit their efforts toward a data sharing initiative.

A MOU will include, but should not be limited to, the exploration of how organizations can participate in the future of data sharing, organizations' participation on Data Governance Committee(s) and data stewardship work groups, and their regular engagement in the overall processes and strategies. The language for this MOU can be leveraged from other comparable community examples. Additionally, participating organizations can provide their own custom language based on similar agreements, such as with their technology vendors or from prior grant initiatives, as well as their standard language for contracting.

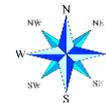
# DATA SHARING AGREEMENTS

## CONSENT TO RELEASE INFORMATION



Recommendation 2.6: Develop a universal Consent to Release Information form that addresses the requirements of federal and state laws that enable organizations to share data for individuals who provide consent

- A universal Consent to Release Information form that addresses the federal law of 42 CFR Part 2 and (740 ILCS 110/) Mental Health and Developmental Disabilities Confidentiality Act should be created to enable participant-level data sharing. This universal form would list the data points that would be shared with the central repository as determined by the data steward workgroups.
- By including all of the information in a single form, the central repository can be designed to manage a single list with controls for the associated data points, such as the expiration date of sharing a particular data point. This standard means that the central repository does not need to be built to adapt to each participating organization's forms and data elements and translate those elements into a standard format.
- Currently, organizations have their own Consent to Release of Information forms which can be customized to meet the organization's current needs. With a universal Consent to Release Information form, organizations may now ask that individuals sign two forms, the universal form for the central repository and a form containing the differential information related to organization-specific forms. This creates an additional operational practice and organizations should weigh the cost of this additional form before agreeing to move forward.



## NORTH HIGHLAND RECOMMENDATIONS

### FORMALIZE CHANGE MANAGEMENT STRUCTURES

**Recommendation 3:** *Formalize Change Management Structures* to support continued engagement with the Lake County behavioral health community through all stages of the future data sharing model development and supporting activities.

[Recommendation 3.1:](#) Develop mechanisms to engage Lake County behavioral health community representatives throughout the data sharing initiative stages regardless of when and how they participate.

[Recommendation 3.2:](#) Develop and formalize processes to identify, understand, document, and respond to sponsor and stakeholder needs.

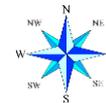
#### Why this recommendation?

In North Highland's experience and in alignment with industry best practices, large-scale initiatives such as the Lake County Data Sharing Project require formalized change management and communication strategies that engage all stakeholders in order to realize the initiative's vision and goals.

#### Background:

Change Management is essential to any initiative as the presence of strategic change management directly impacts the success of any project. Recognizing and adapting to the human component to change can make for a smoother change process, a faster speed of adoption of new practices, and higher quality participation and output.

One of Lake County's strengths is its passionate Coalition and behavioral health community, and understanding how to support its sponsors and stakeholders will be critical to the success of this data sharing initiative. Operationally this includes increasing sponsorship for the program across the community and actively establishing a two-way feedback mechanism from stakeholders to measure the awareness, desire, knowledge, ability, and adoption of the activities included in the future data sharing model to understand how to best respond to and support stakeholders' change needs.

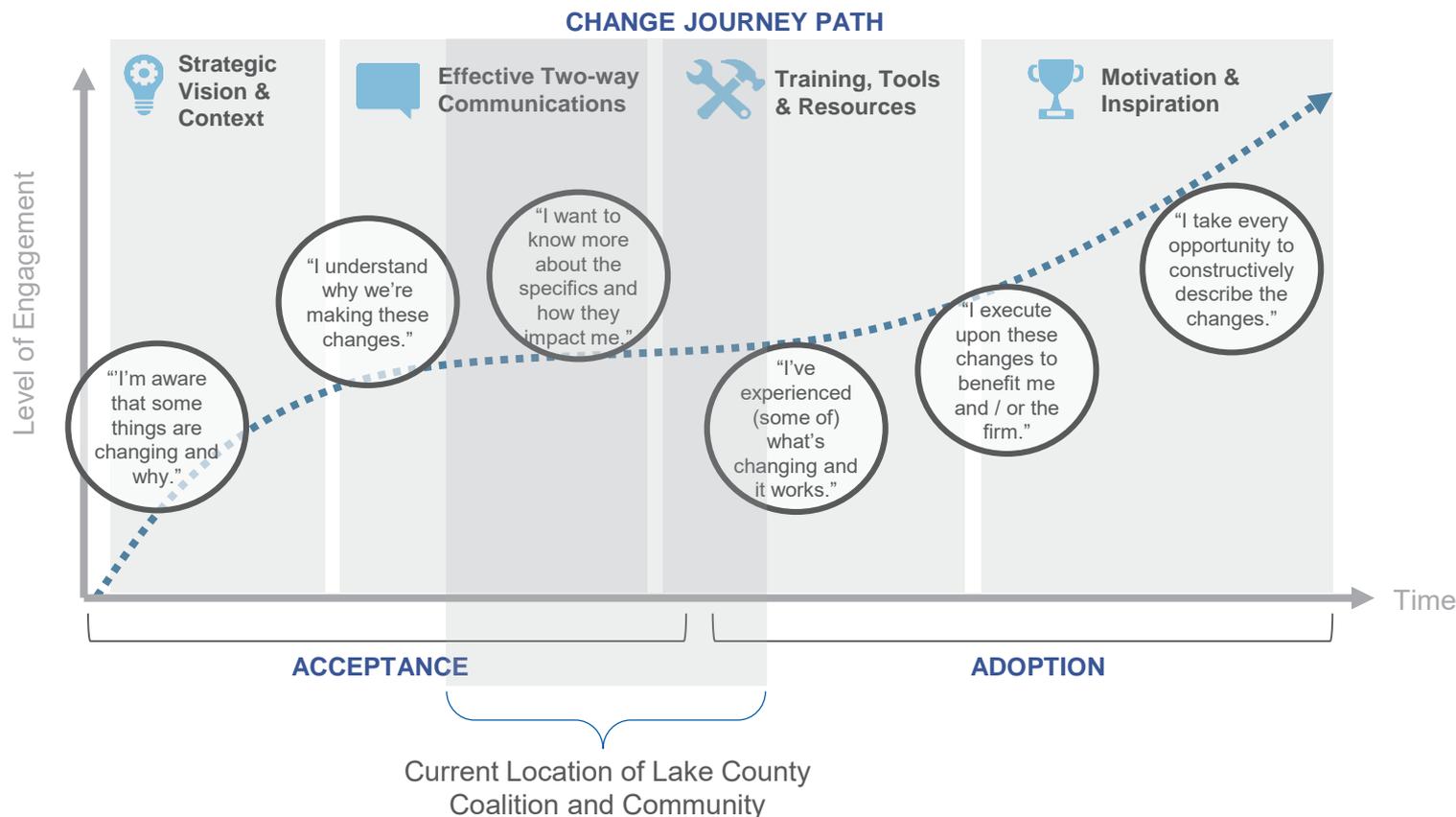


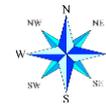
# FORMALIZE CHANGE MANAGEMENT STRUCTURES

## STAKEHOLDER PROGRESSION

The activities to date have helped move the coalition and community members through the change curve by first building greater awareness around the need for data sharing and increasing the desire to participate in data sharing by highlighting its benefits.

Everyone experiences change at a different pace and as a whole, Lake County Coalition members and community members increasingly understand how to participate. Data governance committees need to work with participating organizations to expound upon the details behind how organizations can participate and define per organization what the progression through the remainder of the change curve can look like. This detailed plan will help empower organizations with the knowledge and ability to participate in the future data sharing model and establish organization-specific milestones so that participating organizations can recognize small wins throughout the development of the model.





# FORMALIZE CHANGE MANAGEMENT STRUCTURES

## SPONSOR AND STAKEHOLDER SUPPORT

Data informs better decision making and change management is no exception. It is important to measure how individuals impact and are impacted by the change to help ensure continued progress. When managing a change across organizations, each organization will have its own path towards recognizing the future data sharing model.

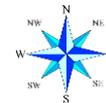
Sponsorship is a key driver for a successful change and understanding the sponsorship dynamic can help influence organizations to participate and move forward with the future data sharing model.

**Sponsorship analysis** – The Coalition should identify the sponsors for the data sharing initiative across-sectors and strategize on leveraging their capabilities and influence to empower others to see the value in data sharing and to become sponsors.

Communications Support: Sponsors are typically senior level individuals that have a high volume of responsibilities and are very busy. Making it as easy as possible to be a sponsor with supporting materials, advice and clear instructions can enable sponsorship and change. Sponsors can meet regularly to discuss strategies and partner with one another to share resources and materials to help ensure consistent communications.

Actively measuring how organizations are progressing along the curve can help predict and inform the change management lever that can help each organization transition through the change.

**Stakeholder Tracking** – Soliciting feedback from organizations on where it falls along the change curve stages of awareness, desire, knowledge, ability, and reinforcement can inform the types of activities, such as sponsorship, communications, training, coaching, or resistance management, that can best support each organization in their progress.



# NORTH HIGHLAND RECOMMENDATIONS

## FOSTER RELATIONSHIPS WITH THE ILLINOIS MEDICAID AGENCY AND MEDICAID MCOS

**Recommendation 4:** *Foster relationships with the Illinois Medicaid Agency and Medicaid Managed Care Organizations (MCOs) to align with common goals and strategies for data sharing and delivering exceptional behavioral healthcare.*

Recommendation 4.1: Lake County stakeholders who are most closely affiliated with Medicaid services should lead the engagement with the Medicaid MCOs to:

- Understand the MCO plans outlined in their proposals that are in alignment and can support data sharing in Lake County
- Foster partnerships within Lake County to:
  - Implement health homes;
  - Expand the use of support services (peer and family support, living skills, employment, and supported housing);
  - Develop community-based crisis services; and
  - Identify and address the needs of individuals who meet the extremely poor functioning criteria, who access behavioral health services for non-emergent conditions at emergency departments or are booked into jail.

Recommendation 4.2: Engage with the Illinois Medicaid Agency to explore options for obtaining claims data information in either the aggregate or at the participant level. It is anticipated that this data can answer the prioritized key questions related to coordinating care for specific individuals.

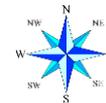
### Why this recommendation?

The research conducted as part of the assessment revealed that Illinois Health and Human Services (HHS) Transformation will significantly alter how behavioral healthcare is delivered in the Lake County behavioral health community. The transformation efforts are in alignment with the vision and goals of the Coalition including data sharing efforts and meeting the behavioral health needs of individuals and families.

National trends show that using centralized data, such as claims data, in data sharing projects increases the depth and breadth of usable data, allowing entities to answer key questions about their population as a whole and individual outcomes. Leveraging data that is already collected and shared (to some degree) at the state level would bolster Lake County's data sharing efforts.

### Background

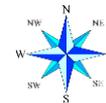
Throughout the nation, health systems are employing new strategies to slow the rate of escalating and unsustainable healthcare costs and improve clinical outcomes. States are transitioning how they purchase Medicaid healthcare services and there is a move from fee-for-service (volume based approaches) to alternative payment mechanisms (pay for value) and are utilizing managed care organizations to deliver on these new approaches.



# NORTH HIGHLAND RECOMMENDATIONS

## ENGAGEMENT WITH THE MEDICAID AGENCIES AND MANAGED CARE ORGANIZATIONS

As discussed in section 3.1 *Research Review*, the Illinois Health and Human Services (HHS) Transformation initiative currently underway is intended to mobilize on similar objectives. As part of this initiative, the Illinois Department of Healthcare and Family Services (state Medicaid agency) has recently awarded contracts to six Managed Care Organizations (MCOs) who will operate throughout the state including in Lake County. There are significant changes that will roll out over the course of the new contracts that will alter the way care is delivered and managed. All providers of care including behavioral health providers will need to adapt to changes to meet the intent of the guiding principles and required delivery approaches. The following are a few examples of forthcoming changes: integrated health homes, increasing real-time data sharing between providers, ability to risk stratify and address needs of the population, movement away from inpatient care to more support services within the community.



## NORTH HIGHLAND RECOMMENDATIONS

### ACCELERATE THE ADOPTION OF MODERN PRACTICES

**Recommendation 5:** Accelerate the adoption of modernized healthcare, business operations, clinical best practices that achieve better outcomes, experience, and efficiencies.

**Recommendation 5.1:** Identify and communicate to behavioral health service providers national and other local learning opportunities focused on healthcare transformation initiatives.

**Recommendation 5.2:** Develop learning opportunities that are targeted to the specific needs of behavioral health service providers within Lake County. The following are examples of learning opportunity topics: 1) develop or consolidate back-office operations that increase a behavioral health service providers' ability to perform in the new era of healthcare delivery; 2) use clinical and operational best practices for achieving and documenting clinical outcomes (e.g. risk stratification).

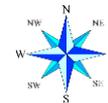
#### **Why this recommendation?**

National and state trends point towards efforts that transformed the paradigm in how healthcare is delivered and managed. Healthcare systems are being transformed in order to achieve the nationally accepted Triple Aim which is to 1) improve the experience of care; 2) improve the health of populations; and 3) reduce the per capita cost of healthcare. Healthcare providers including behavioral health providers around the nation and within Lake County will have to operate under a new clinical and operational paradigm to remain viable within the new healthcare business environment.

Behavioral health providers within Lake County must be able to access knowledge from others as well as best practices in the field to be better positioned to become exceptional in delivering clinical best practices and business operations. While many already seek out learning opportunities, Lake County behavioral health providers can benefit from both individual and collective learning opportunities.

#### **Background:**

As discussed in 3.1.2 *National and Local Trends Impacting Behavioral Health*, behavioral healthcare systems are transforming to address the needs of individuals and families while slowing the rate of unsustainable and escalating healthcare costs and improving clinical outcomes. Through the current data sharing assessment process, it was shown that the ability of behavioral health providers to utilize current technologies (e.g. EHRs, analytic tools) varied significantly. Not having an EMR adversely impacts a behavioral health provider's ability to share data electronically.



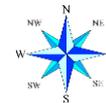
## NORTH HIGHLAND RECOMMENDATIONS

### ACCELERATE THE ADOPTION OF MODERN PRACTICES

#### Background (cont.):

Behavioral health providers without current EHR capabilities will have to be on a distinctive path to acquiring the internal business operation tools such as an EHR in order to support their long term participation in the future data sharing initiative. Additional technology and streamlining operations potentially through back-end shared services can alleviate the demands of participating in a future data sharing models, and on other activities, for an already cross trained workforce.

Further, the need to have electronic capabilities is not limited to participating in the future data sharing initiative but also being viable and sustainable in the ever-changing landscape of healthcare delivery in the US. This includes but is not limited to being able to navigate in the new payment structures, which entails being able to demonstrate effectiveness, efficiencies, and clinical outcomes. This journey of moving to more sophisticated business operations is taking place all around the nation for providers of both physical health and behavioral health services.



# NORTH HIGHLAND RECOMMENDATIONS

## EXPAND THE BEHAVIORAL HEALTH SERVICES CONTINUUM

**Recommendation 6:** Support *expansions or shifts in the behavioral health services continuum* to better align services with community needs

Recommendation 6.1: Develop strategies for expanded support and crisis services with an emphasis on implementing the latest clinical and operational best practices that support individuals and families in community settings. These include changes such as crisis call command center, crisis mobile teams operating in the community, crisis walk-in centers that can accept individuals with mild-to-acute crisis needs, crisis follow-up phone calls, community response, peer and/or family support, and appointments with on-going service providers.

Recommendation 6.2: Collect data from stakeholders, such as 911 dispatch, law enforcement, jail and emergency departments that can inform crisis service capacity development needs. Within the Data Sharing Pilot Project, immediately focus on collecting and standardizing available data from jails and emergency rooms while beginning to identify and standardize the types of data to collect from 911 dispatch and law enforcement.

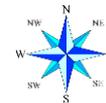
Recommendation 6.3: Research and collect crisis service capacity development information from other communities (e.g., availability of service per 100,000, from communities that have crisis services with the most contemporary service provision characteristics).

Recommendation 6.4: Design data collection practices to measure capacity and impact as new support and crisis services are developed. Measures should be consistent with how other communities are measuring support and crisis services.

### Why this recommendation?

National and state trends point towards transformation efforts that change the paradigm in how healthcare is delivered and managed. In order to achieve the goals of the Triple Aim, service continuum designs are being reinvented to optimize the use of community-based services as an alternative to high cost, facility-based continuum. In order to address the national and local paradigm shifts the Lake County behavioral health community will need to expanded support services and crisis services at the community level.

Further, the national research shows that there are best practices for identifying and collecting data for the full continuum of services including support and crisis services. The Lake County behavioral health community can adapt and utilize some of these promising data collection and reporting practices.

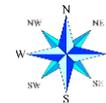


# NORTH HIGHLAND RECOMMENDATIONS

## EXPAND THE BEHAVIORAL HEALTH SERVICES CONTINUUM

### Background

As discussed in *3.1.2 National and Local Trends Impacting Behavioral Health*, national and local healthcare systems are transforming to address the needs of individuals and families while slowing the rate of unsustainable and escalating healthcare costs and improving clinical outcomes. Many communities are employing various strategies to address these aims including expanding support services and crisis services. Further, based on information gathered through the Current Data Sharing Assessment, there is minimal *aggregated data readily available* within the behavioral health community to inform crisis service capacity development nor is there *organized aggregated data from system partners* who could provide demand data such as 911 dispatch and law enforcement responses within the community related to behavioral health and emergency department utilization for behavioral health conditions.



## NORTH HIGHLAND RECOMMENDATIONS

### INFLUENCE FEDERAL AND STATE LAWS

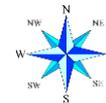
**Recommendation 7:** *Influence federal and state laws* that support the active sharing of information to coordinate care, while also safeguarding privacy.

Recommendation 7.1: Engage state lawmakers to either amend or repeal 740 ILCS 110 to support the active sharing of information to coordinate care while also safeguarding privacy in alignment with federal laws including HIPAA and HITECH laws.

Recommendation 7.2: Identify strategies to engage the federal lawmakers on current initiatives to amend laws (42 CFR Part 2) to support the active sharing of information to coordinate care while also safeguarding privacy.

#### **Why this recommendation?**

North Highland heard stakeholders convey some valid data sharing concerns due to legal barriers. To overcome such barriers, the Coalition should pursue influencing federal and state laws to increase data sharing potential in a respectful and secure way. The research conducted showed that many states currently have or are in the process of creating more flexible laws that enable data sharing, and the federal trend is increasing data sharing to improve the quality of care and care coordination while securing the data and safeguarding privacy.



# INFLUENCE FEDERAL AND STATE LAWS

## IMPACTING MENTAL HEALTH AND DEVELOPMENTAL DISABILITY CONFIDENTIALITY ACT

Below are the detailed recommendations for impacting the Mental Health and Developmental Disability Confidentiality Act (740 ILCS 110).

### Specific language recommendations

#### CURRENT LANGUAGE IN 740

“HIE” is defined broadly as an exchange or organization overseeing and governing electronic exchange of health information pursuant to 20 ILCS 3860.

“Written” and “in writing” appear frequently without specific reference to paper or electronic media.

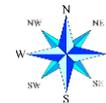
#### LANGUAGE RECOMMENDATION

Add language to support a continuum of data sharing practices beyond the “point-to-point” method implicit in 740

Amend 740 to make potential electronic consents more explicit to prevent organizations establishing less than optimal data sharing and release precedents ill-aligned with serving the population

### Broader recommendations

- **Repealing the law** would help eliminate a state privacy law more strict than HIPAA and promote data sharing
- Amending the law to **address the current vernacular that lends itself to conservative interpretation** and include additional language to protect non-paper-based media as well as partnerships with more effusive sharing practices than mere “point-to-point” interactions.
- The additional fields mandated on the release of information forms required by 740 ILCS 110 extend beyond HIPAA’s limitations and curtail sharing practices between providers. This issue could be helped by **allowing an electronic “accept all” option.**
- Research and **provide education around the intent of the law** and the interpretation continuum for the law to help get organizations practicing the same interpretation.



## INFLUENCE FEDERAL AND STATE LAWS IMPACTING 42 CFR – CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS

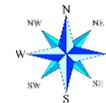
Engaging with federal lawmakers and other interested stakeholders to address aspects of 42 CFR Part 2 could make a difference in appropriate sharing of critical treatment information while also safeguarding from inappropriate use of information.

There is current dialog at the national level and some initial legislation being drafted that is focused on amending federal regulations related to substance use health records (42 CFR Part 2), which currently prohibit widespread sharing of patients' addiction treatment history. This has been sparked by the need to address the national epidemic of opioid abuse.

Specifically, Rep. Murphy and other bill sponsors and supporters have drafted the Overdose Prevention and Patient Safety Act (OPPS Act). Originally, 42 CFR Part 2 was meant to protect confidentiality and encourage those living with addictions to seek treatment. Rep. Murphy and colleagues believe that the unintended consequences of this regulation led to doctors prescribing and making treatment decisions without information about their patients' history with substance use disorders. The OPPS Act would bring 42 CFR Part 2 in line with the Health Insurance Portability and Accountability Act (HIPAA) as it pertains to substance use disorder information.

Of importance to many providers and individuals that use addiction treatment services, is that the legislation makes it clear that these records are prohibited from being used as evidence or a basis to press charges in criminal cases against patients.

“You cannot treat the whole patient with half of their medical record. In order to help turn the tide on this crisis and prevent more drug overdose deaths, physicians must have access to their patient’s entire medical history,” said Rep. Murphy. “The Overdose Prevention and Patient Safety Act will allow doctors to deliver optimal, lifesaving medical care while maintaining the highest level of privacy for the patient.”



## NORTH HIGHLAND RECOMMENDATIONS

### EXPLORE POTENTIAL FUNDING MECHANISMS

**Recommendation 8:** *Explore potential funding mechanisms* to establish a financially sustainable data sharing program.

Recommendation 8.1: Research federal funding opportunities through the Center for Medicare and Medicaid Services (CMS) – the Medicaid funding and oversight body.

Recommendation 8.2: Research local and private funding opportunities.

Recommendation 8.3: Based on research, develop a financially sustainable data sharing program.

#### **Why this recommendation?**

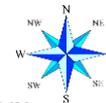
Federal funding is available to entities involved in sharing data. Lake County could explore obtaining such funding in cooperation with the MCOs and/or Medicaid. Additional research may also include understanding if and how organizations can fund shared resources.

---

# **6. Coalition Preferred Action Plan Go First Strategies**

# GO FIRST STRATEGIES

## INTRODUCTION

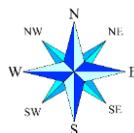


The Coalition is committed to advancing sustainable community-level change through collaborative efforts, such as enhanced system-wide data sharing, coordination, and collaboration, in order to better leverage existing limited resources and maximize the impact.

Having a guiding Data Sharing Vision can subsequently enable broad strategies to progress towards that vision and action towards its purpose and design in alignment with these principals. As observed in other communities, once a vision is recognized, stakeholders get started in prototyping and testing efforts that move the community closer to that vision. If channeled in alignment with the recommendations, this action can help the Lake County behavioral health community to begin recognizing progress towards this vision as well as small wins through data sharing.

To translate this vision into action, the eight distinct recommendations and corresponding actionable “Go First” strategies were developed.

Go First Strategies are tangible, next step actions that are in alignment with the broad Recommendations and can be acted upon concurrently to guide the Lake County behavioral Health community in their efforts to “just get started.” These strategies are intended to be directional in nature, with more detailed project plans to be developed. The success metrics are a guide for moving in the right direction and should be refined during the implementation planning phase. The below compass is a symbolic reminder that, like the recommendations, these strategies can adapt to meet the needs of the Lake County behavioral health community while moving the community in the right direction, towards its vision and goals.



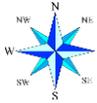
Below is a list of the Go First Strategies recommended for the Lake County behavioral health community and these are described in greater detail in the following materials. These are listed in no particular order as they are intended to start simultaneously.

- Implement a Data Sharing Pilot Project
- Develop and Mobilize on Data Governance Structures and Activities
- Formalize Change Management Structures
- Engage with Medicaid Managed Care (MCO) Organizations
- Identify Knowledge Opportunities for Behavioral Health Providers
- Support Expanding the Behavioral Health Services Continuum
- Influence Federal and State Laws
- Explore potential funding mechanisms

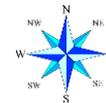
The Coalition can adopt these eight Go First Strategies as a first step towards eventually achieving its future vision for data sharing.

# GO FIRST STRATEGIES

## IMPLEMENT A DATA SHARING PILOT PROJECT



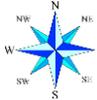
1. Implement a Data Sharing Pilot Project	
Activities	Anticipated Benefits
<p>A. Design a Data Sharing Pilot Project engaging early adopters from several cross system partners including behavioral health providers, Emergency Departments, Lake County Jail and Lake County Probation.</p> <p>B. Plan and design a simple and low tech solution for collecting aggregated data and preparing reports.</p>	<p>A pilot project will:</p> <ul style="list-style-type: none"> <li>▪ Afford the Coalition an opportunity to test initial data collection and reporting strategies that can then be used to inform a future larger scale data sharing plan.</li> <li>▪ Support the initial collection of some crucial information that can be used for planning and oversight purposes.</li> </ul>
<p><b>Why this Go First Strategy?</b> A Pilot project will support the overall understanding of what needs to happen to develop a framework to support decision making, including what data is needed to answer what questions, the data governance that needs to be in place, and what technical systems and applications will be used. As a result, Memorandum of Understandings (MOUs), Data Sharing Agreements and General Release of Information forms can be designed and developed for the pilot, while also aiming towards the vision. Additionally, a Pilot will provide what worked, what needs improvement, and understanding and realization of the anticipated benefits.</p> <p><b>Success</b> = Initial report/visualization/dashboard of key aggregated data and lessons learned.</p>	



2. Develop and Mobilize on Data Governance Structures and Activities	
Activities	Anticipated Benefits
<p>A. Design and implement Data Governance Structures and Activities. Structures should consider some of the short and long-term needs of data sharing initiative. Data Steward Workgroups should be mobilized to focus on the plans for the Data Sharing Pilot Project and <b>prioritize data</b> that supports answering questions such as:</p> <ul style="list-style-type: none"> <li>▪ Who is accessing behavioral health services in community settings and some basic information about their needs and life functioning abilities?</li> <li>▪ Are services being provided in a timely manner to address individual and family service needs?</li> <li>▪ How many individuals are accessing behavioral health services in Emergency Departments, what are their needs and where are they dispositioned to and how long does that take?</li> <li>▪ How many individuals who are booked into jail that have a behavioral health need? Where are they referred for services and how long does it take to access care?</li> <li>▪ How many individuals who are on Probation have a behavioral health need? Where are they referred for services and how long does it take to access care?</li> </ul> <p>B. Develop and execute MOUs for all Lake County behavioral health community stakeholders who are willing to commit their efforts toward a data sharing initiative. The content of the MOU could include but not be limited to committing to engage and explore how they can participate in the future of data sharing, participation on Data Governance Committee(s) and regular engagement in the overall processes and strategies.</p>	<p>Any data sharing process must have the appropriate structures and processes in order to safeguard the success of data sharing.</p> <p>The prioritized initial data to collect can be used for planning and oversight purposes.</p> <p>The focus of the initial data can offer some information about the overall behavioral health population while also learning about those who use Emergency Departments, are booked into jail and/or are on Probation.</p> <p>Development and execution of MOUs advance the level of engagement and commitment on the part of the Signors improving the likelihood of achieving the agreed upon goals.</p>
<p><b>Why this Go First Strategy?</b> Just as a framework for sharing data needs to be established, the rules, processes, and procedures to share data need to be established. In conjunction with the Pilot in the first Go First Strategy, developing data governance structures and activities will result in participants clearly understanding what’s being shared and why through MOUs, Data Sharing Agreements and General Release of Information forms. As a result, the agreements be designed and developed for the pilot, with the future state vision in mind and taking steps toward that vision.</p>	
<p><b>Success</b> = Established data governance groups, data governance for the Pilot project, and signed MOUs.</p>	

# GO FIRST STRATEGIES

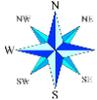
## FORMALIZE CHANGE MANAGEMENT STRUCTURES



3. Formalize Change Management Structures	
Activities	Anticipated Benefits
<p>A. Develop mechanisms to engage all data sharing initiative stakeholders throughout the data sharing initiative stages, regardless of when and how they participate.</p> <p>B. Develop and formalize processes to identify, understand, document, and respond to sponsor and stakeholder needs.</p>	<p>Change management strategies are critical to the success of any project. Given the complexities of the Lake County data sharing initiative, it is even more important that strategies are developed to accommodate the varied needs of the diverse stakeholders.</p> <p>Implementing change management strategies will enable the success of the initiative.</p>
<p><b>Why this Go First Strategy?</b> Projects generally fail due to the lack of effective change management and communication. To give the data sharing project the greatest chance of success, Lake County should include the ADKAR concept: A – Awareness of the need for change, D – Desire to support the change, K – Knowledge of how to change, A – Ability to demonstrate new skills and behaviors, and R – Reinforcement to make the change stick (PROSCI©)</p> <p>Additionally, communication and clear understanding of these roles: Responsible (who needs to do what), Accountable (ultimately answerable for a decision or activity), Consult (who needs to be consulted before a decision is made; input is required), and Inform (who needs to be informed after a decision is made) – also known as a RACI Matrix.</p> <p><b>Success</b> = Invested stakeholders and buy-in; ultimately leading to a successful Pilot project.</p>	

# GO FIRST STRATEGIES

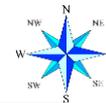
## ENGAGE WITH MEDICAID MANAGED CARE MCO ORGANIZATIONS



4. Engage with Medicaid Managed Care (MCO) Organizations	
Activities	Anticipated Benefits
<p>A. Understand the MCO plans outlined in their Medicaid proposals that are in alignment and can support data sharing in Lake County.</p> <p>B. Understand and foster partnerships with MCOs on Illinois Medicaid initiatives such as:</p> <ul style="list-style-type: none"> <li>▪ Implement health homes;</li> <li>▪ Expand the use of support services (peer and family support, living skills, employment and supported housing);</li> <li>▪ Develop community-based crisis services; and</li> <li>▪ Identify and address high need individuals such as those with extremely poor functioning, who access ED or are booked into jail.</li> </ul>	<p>A partnership with the Medicaid MCOs can accelerate solutions and foster mobilization on many of the priorities outlined by the Lake County behavioral health community which are in alignment with the Illinois Health and Human Service Transformation Initiative that MCOs are responsible for carrying out.</p> <p>Some of the commonalities include:</p> <ul style="list-style-type: none"> <li>▪ Fostering a system that utilizes a person-centric approach to services that meet the physical, behavioral and social support needs of individuals and families;</li> <li>▪ Designing a delivery system that addresses the full continuum of care needs including crisis and support services;</li> <li>▪ Realigning financial resources that result in better care, better outcomes and better experience of care;</li> <li>▪ Utilizing technology-enabled solutions; and</li> <li>▪ Utilizing analytics and reporting.</li> </ul>
<p><b>Why this Go First Strategy?</b> Leveraging projects and initiatives in Illinois that align to the Data Sharing vision, whether in supporting data collection, improving behavioral health outcomes, or improving the individual experience are steps that can advance the Coalition’s goals and timetable. For example, getting claims data from Medicaid or the MCOs would go a long way in collecting data to be used to answer key questions.</p> <p><b>Success</b> = Access to and receipt of Medicaid participant level claims data; initial engagements and partnerships established to understand the Medicaid/MCOs plans to share data and improve behavioral health access, care and services.</p>	

# GO FIRST STRATEGIES

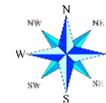
## IDENTIFY OPPORTUNITIES FOR BEHAVIORAL HEALTH PROVIDERS



5. Identify Knowledge Opportunities for Behavioral Health Providers	
Activities	Anticipated Benefits
<p>A. Identify and communicate to behavioral health providers national and other local learning opportunities that are focused on health care transformation initiatives that support the acceleration of clinical best practices and business operations such as data sharing and interoperability.</p> <p>B. Develop learning opportunities that are targeted to the specific needs of behavioral health providers within Lake County. The following are examples of learning opportunity topics:</p> <ul style="list-style-type: none"> <li>▪ Developing or consolidating back-office operations that increase a behavioral health providers' ability to perform in the new era of healthcare delivery (e.g. use of electronic systems, data collection, analysis, and reporting); and</li> <li>▪ Using clinical and operational best practices for supporting, achieving and documenting clinical outcomes (e.g. risk stratification).</li> </ul>	<p>The ultimate purpose of the Coalition is to enable individuals and families with behavioral health needs to have access to a coordinated, integrated, well-funded mental health system that promotes recovery and social inclusion through timely access to prevention, treatment, and recovery support services. (Coalition Charter)</p> <p>As such, in order to realize the aforementioned vision, it is imperative that those who are entrusted to be the providers of behavioral health services are exceptional in delivering clinical best practices and business operations.</p> <p>Further, efforts by individual organizations must be made in concert with the behavioral health delivery system as a whole in order to realize the principles of the Coalition as well as fulfill their own vision, mission, and goals.</p> <p>Through individualized and collective learning opportunities the behavioral health provider community can accelerate their journey towards exceptional service provision and business operations.</p>
<p><b>Why this Go First Strategy?</b> In order to position behavioral health providers to become exceptional in delivering clinical best practices and business operations, they must be able to access knowledge from others and from best practices as defined in the field. While many already seek out learning opportunities, Lake County providers can benefit from individual and collective learning opportunities that take them to the highest level obtainable.</p> <p><b>Success</b> = Behavioral health providers will be aware of and engaged in additional learning opportunities.</p>	

# GO FIRST STRATEGIES

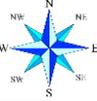
## SUPPORT EXPANDING THE BEHAVIORAL HEALTH SERVICES CONTINUUM



6. Support Expanding the Behavioral Health Services Continuum	
Activities	Anticipated Benefits
<p>A. Develop strategies for expanded support services and crisis services.</p> <p>The strategies should include an emphasis on the most contemporary clinical and operational best practices that support individuals and families in community settings.</p> <p>The focus of the work should be done in tandem the work of collaborating with MCO's.</p> <p>The focus of strategies should include a focus on services such as crisis call command center, crisis mobile teams operating in the community, crisis walk in that can accept individuals with mild to acute crisis needs, crisis follow-up through phone calls, community response, peer and or family support and appointments to on-going service providers.</p>	<p>Expanding the behavioral health services continuum will support the Coalition and Lake County behavioral health community in achieving conveyed priorities and Guiding Principles such as delivering care that is:</p> <ul style="list-style-type: none"> <li>▪ Person-centered;</li> <li>▪ Strengths-based;</li> <li>▪ Evidence-based, evidence-informed, best, and emerging promising practices;</li> <li>▪ Community-based and provided at the most appropriate level to meet the presenting needs; and</li> <li>▪ Collaborative and address the service response needs of system partners such as emergency departments and the justice system partners.</li> </ul> <p>Additionally, expanding the behavioral health services continuum will support the Coalition and Lake County behavioral health community in aligning with national and local health and human service transformation initiatives.</p>
<p><b>Why this Go First Strategy?</b> National trends point to person-centered care. In order to meet the needs of the Lake County community, there is a need to expanded support services and crisis services at the community level.</p> <p><b>Success</b> = Collaboration established with the MCOs to plan and develop strategies to expand support services and crisis services.</p>	

# GO FIRST STRATEGIES

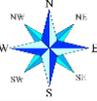
## INFLUENCE FEDERAL AND STATE LAWS



7. Influence Federal and State Laws that can support the active sharing of information to coordinate care while also safeguarding privacy.	
Activities	Anticipated Benefits
<p>A. Develop strategies to either amend or repeal 740 ILCS 110 to support the active sharing of information to coordinate care while also safeguarding privacy in alignment with federal laws including HIPAA and HITECH laws.</p> <p>B. Identify strategies to engage lawmakers about current initiatives to amend laws (Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2)) to support the active sharing of information to coordinate care while also safeguarding privacy (i.e., sending letters to senators/representatives, and thereby taking an active role in the federal dialogue).</p> <p>Upon agreement of strategies by the Coalition, engage with applicable state or federal lawmakers.</p>	<p>Amending or repealing laws will support the active sharing of information to coordinate care while also safeguarding privacy.</p>
<p><b>Why this Go First Strategy?</b> Changes to laws to contain more data sharing friendly language increases the chance of successful data sharing by reducing real or perceived barriers.</p> <p><b>Success</b> = Strategies developed to engage lawmakers.</p>	

# GO FIRST STRATEGIES

## EXPLORE POTENTIAL FUNDING MECHANISMS



8. Explore potential funding mechanisms to establish a sustainable data sharing program.	
Activities	Anticipated Benefits
A. Research federal funding and local and private funding opportunities.	Coalition is aware of potential funding mechanisms to build on investments already made.
<p><b>Why this Go First Strategy?</b> As we've seen in the comparable communities, several rely on a breadth of resources to reach their goals. Funding that builds upon investments already made by Lake County for the Data Sharing Project is important for both short and long-term success.</p> <p><b>Success</b> = Compilation of funding possibilities.</p>	

---

# 7. Appendix

# LAKE COUNTY MENTAL HEALTH COALITION CHARTER

## OVERVIEW

Lake County recognizes that the national and local mental health crisis impacts everyone. To address this crisis, the Lake County Mental Health Coalition (LCMHC) was convened. The LCMHC is a community-based initiative made up of a diverse group of stakeholders representing government, hospitals, public health, spiritual/clergy/religious/pastoral care, housing/homeless assistance, law enforcement, justice partners, community health providers, and private philanthropic funders who are focusing on data-sharing and evidence-based practices to address gaps in Mental, Emotional, and Behavioral (MEB) health services, and development of a connected sustainable continuum of care for this vulnerable population.

## VISION

The Illinois Mental Health Services Strategic Planning Task Force, as established by the Illinois State Legislature in August 2011 (Pub. Act 097-0438) published the *Illinois Mental Health Strategic Plan*, which is a strategic plan for the delivery of mental health services in Illinois during 2013-2018. The plan identifies a Vision to achieve an efficient, effective, high-quality mental health service delivery system. The LCMHC's vision can mirror the State of Illinois, which states:

*In Illinois, we envision: All adults with a diagnosis of, or at risk for developing, a mental illness will have access to a coordinated, integrated, well-funded mental health system that promotes recovery and social inclusion through timely access to prevention, treatment, and recovery support services.*

## PURPOSE

The purpose of the Lake County Mental Health Coalition is to advance sustainable community-level change through collaborative efforts, such as enhanced system-wide data sharing, coordination, and collaboration, in order to better leverage existing limited resources, and maximize the impact. Additionally, the LCMHC will work collaboratively to develop a positive public awareness campaign to decrease stigma and increase an awareness of available resources for mental, emotional and behavioral (MEB) health needs.

Coalition members will strive to answer these questions:

- How to better understand the mental health needs of the Lake County population as a whole across organizations and systems
- How to communicate and share throughout the community that MEB illness is preventable and treatable?
- How to enhance programs to prevent MEB illness?
- How to share data to track persons' intercept with systems and make connections between the different services?
- How individuals access the optimal service regardless of where they enter the system?
- How to enhance the network of services to improve the continuum of care for MEB health?
- How to connect the multiple systems to provide better care coordination?

Studies reveal there is a greater chance of success when different groups collaboratively organize around outcomes, especially when tackling social issues. While there are many successful programs in Lake County, they are too often doing this good work in silos. There needs to be more coordination and a systematic solution to support the alignment of resources to make a significant, ongoing collective impact. The LCMHC will explore and identify the common goals and mutual benefits for all stakeholders (government, hospitals, police, community partners, and more).

## OBJECTIVES

The ultimate objective of the Coalition is to prevent and reduce MEB health illness, including substance use disorders among adults through data-sharing and researched-based best practices designed specifically for Lake County to form stronger prevention, build capacity, address gaps, and enhance services.

To accomplish this, the Coalition will:

- Actively collect, share, and review the various disparate data sets to understand the prevalence of MEB health illness, and breadth of existing services and programs in Lake County.
- Build connections through improved data-sharing among fragmented and siloed services in order to align the services with the needs, at the appropriate level, and the optimal time.
- Address the factors in a community that increase or contribute to the risk of MEB health illness/crisis, promote the factors that minimize the risk, support, expand, and enhance preventative strategies.

## OUTCOMES

- Collect and share data and analysis on local MEB health, including current services and demand need for service;
- Develop a framework and systems to consistently share data across communities and use that data to inform and create more efficient services;
- Use data to identify needs and gaps in service and then align and prioritize that list;
- Recommend policy and practices necessary to build capacity, address gaps, and enhance services;
- Build upon existing bodies of research regarding best practices and evaluate them for their applicability in Lake County;

- Design and implement a positive public awareness campaign to decrease stigma and improve health literacy by increasing an awareness of available resources for behavioral health needs, and coordinate existing community awareness efforts.

## GUIDING PRINCIPLES

The State of Illinois uses the following principles to guide the design, delivery, and evaluation of all MEB health illness prevention, treatment, and recovery support services in Illinois. The LCMHC's efforts align with these principles:

- Services for adults with MEB health conditions are person centered, strengths based, trauma informed, and culturally competent. Services are founded on evidence-based, evidence-informed, best, and emerging promising practices.
- Services are flexible, tailored, and provided in the least restrictive setting appropriate to the individual's needs.
- Adults with MEB health illnesses are provided with the support and housing, and when applicable supportive employment. Children with emotional disorders have access to a broad, flexible array of effective community-based services and supports that are integrated at the system level and individualized to each child's and family's needs.
- The direct and immediate involvement of individuals with lived experience of MEB health illnesses to better understand and access the available continuum of care. Individuals with MEB health, health conditions are served wherever and whenever they present for care ("no wrong door").
- Services are integrated, to the greatest extent possible, across MEB health and primary care settings. Individuals involved with the criminal justice system are diverted to MEB health treatment and services as appropriate to their situation and with regard for public safety. Individuals in crisis are deflected from the criminal justice system when public safety deems the MEB health system is a more appropriate alternative.
- Outcomes are standardized and measured at the individual, provider, and service system level. Outcome data drives quality improvement efforts.

- The MEB health workforce is sufficiently sized, appropriately trained, and properly credentialed.
- Funding for MEB health services is appropriate to meet identified needs and priorities within budgetary constraints. All additional sources of funding (federal, state, private, insurance, etc.) are maximized.

## RESPONSIBILITIES & GENERAL PRINCIPLES OF COLLABORATION

Members are asked to represent the interests of their respective groups and audiences and serve as advocates for the Coalition's charge. As such, members' responsibilities include, but are not limited to:

- Attend meetings, actively engage in discussion, and come prepared to advance meeting outcomes.
- Honor the knowledge in the room.
- Ask questions and seek clarification to ensure understanding of other's interests, concerns and comments.
- Listen and be open to viewpoints that may be different from your own and critical feedback.
- Develop reports, presentations, and other documents, as requested.
- Share data, information, and resource materials to represented groups and organizations.
- Invest time, energy and organizational resources necessary to carry out the LCMHC's objectives and encourage other colleagues and community members to do the same.
- Regard disagreements as problems to be solved rather than battles to be won.
- Be prepared to "think outside the box" and develop creative solutions to address the many interests that will be raised throughout the Coalition's deliberations.

- The LCMHC’s mission will be best achieved by relationships among the members characterized by mutual trust, responsiveness, flexibility, and open communication.
- Work toward the LCMHC’s common goals.

## MEMBERSHIP

The Committee membership is listed in Attachment A. The term is for the duration of the committee’s work.

\*Portions adopted from:

- California DHCS, Healthcare Reform Committee  
[http://www.dhcs.ca.gov/services/MH/Documents/05b%20Healthcare%20Reform\\_Charter\\_v3%20sr\\_2011-03-26.pdf](http://www.dhcs.ca.gov/services/MH/Documents/05b%20Healthcare%20Reform_Charter_v3%20sr_2011-03-26.pdf)
- Illinois Mental Health Strategic Plan (2013-2018)

## Appendix 7.2: Glossary of Terms

### Glossary of Terms

**At Rest** – Refers to the condition of data. Data at rest refers to data that is not "moving" through networks.

**Behavioral Health** – Includes mental health and substance abuse conditions and/or treatment. This terminology is in uniform with other developing national language consistent with integrated treatment approaches. Behavioral health as it reads in this report is inclusive of mental, emotional, and behavioral health as described in the Lake County Mental Health Coalition's Charter.

**Break the Glass** – Break the glass (which draws its name from breaking the glass to pull a fire alarm) refers to a quick means for a person who does not have access privileges to certain information to gain access when necessary.

**Change Management** – Refers to the discipline that guides how we prepare, equip and support individuals to successfully adopt change in order to drive organizational success and outcomes. While all changes are unique and all individuals are unique, decades of research shows there are actions we can take to influence people in their individual transitions. Change management provides a structured approach for supporting the individuals in your organization to move from their own current states to their own future states.

**Coalition** – Refers to the Lake County Mental Health Coalition. The Coalition consists of representatives from a diverse group of impacted organizations:

- Government
- Hospitals
- Public health
- Spiritual/clergy/religious/pastoral care
- Housing/homeless assistance
- Law enforcement
- Justice partners
- Education
- Advocacy organizations
- Community health providers, including behavioral healthcare, and
- Private philanthropies

**Data Owners** – Refers to the organization that have the legal rights and complete control over a single piece or set of data elements, as well as owns the policies and practices of sharing that data.

**Data Sharing Project** – Refers to all tasks, activities, and outcomes related the data sharing engagement with North Highland to date. The term data sharing initiative refers to the overall work of the intuitive and data sharing goal of the Lake County behavioral health community

## Appendix 7.2: Glossary of Terms

**Hot Spotting** – Refers to a data-driven process for the timely identification of extreme patterns in a defined region of the healthcare system. It is used to guide targeted intervention and follow-up to better address patient needs, improve care quality, and reduce cost.

**Lake County behavioral health community** – Includes the network of entities across healthcare organizations, the justice system, and community organizations that are involved in or impacted by behavioral health.

**Lake County Government** – Refers to individuals employed by Lake County.

**Metadata** – Metadata is data about data. In other words, it is data that is used to describe another item's content.

**R-code** – term used to describe the Illinois Uniform Crime Reporting (IUCR) codes. These codes are four digit codes that law enforcement agencies use to classify criminal incidents when taking individual reports.

**Recidivism** – Refers to a tendency to relapse into a previous condition or mode of behavior.

**Service Point** – ServicePoint is used by more than 70% of the U.S. Department of Housing and Urban Development's (HUD) Continuum of Care (CoC) communities. So much more than just an HMIS (Homeless Management Information System), ServicePoint is a flexible, web-based software system used by human services organizations to easily manage and coordinate services, guide resource allocation, and demonstrate effectiveness.

**Speed of Trust** – is a phrase used within change and data sharing literature to describe the pace at which a change and/or the sharing of data with move. Building trust is critical and the following strategies are recommended to support the development, and ultimate signing of, data sharing agreements across stakeholders and enable a data sharing initiative

**System partners** – Refers to a working relationship between entities within the behavioral health community, such as service providers.

**Triple Aim** – Refers to the goals of improving the patient experience and the health of populations while reducing the cost of care. The goals of the Triple Aim are to 1) Improve the experience of care, 2) Improve the health of populations, and 3) Reduce the per capita cost of healthcare.

## Appendix 7.3: Current Data Sharing Assessment Interviewee List

### Interviewee List

Below are stakeholders across the Lake County behavioral health community that the North Highland team interviewed during the Current Data Sharing Assessment research process. These contacts were provided or recommended by Coalition and community members and by interviewees.

First Name	Last Name	Title	Organization
Betsy	White	Senior Clinical Program Manager, Outpatient Psychiatry	Northshore University Health System
Brenda	O Connell	Continuum of Care Program Coordinator	Lake County Government
Bruce	Johnson	CEO	NICASA
Cindy	Guerra	IT	A Safe Place
Clinton	Herdegen	Police Chief	Libertyville Police Department
Collins	Seamus	Vice President Operations	Lake Forrest Hospital (Northwestern Memorial Healthcare)
Danielle	Meyer	Chief Nuclear Medicine Technologist	North Shore Community Health System
David	Hare	Chief of Operations	Lake County Sherriff Office
David	Wathen	Chief of Corrections	Lake County Sherriff Office
Deborah	Taber	Administrative Director, Psychiatry	NorthShore University Health System
Debra	Susie Lattner	Vice President of Medical Management	Advocate Condell Medical Center
Dominica	Tallarico	President	Advocate Condell Medical Center
Dora	Maya	President and CEO	Arden Shore Child Family Service - Mental Health Collaborative
Doug	Kasamis	IT Manager	Lake County Health Department
Doug	Kasarnis	Director of IT	Lake County Health Department
Emperatriz	Guerra	Director of Behavioral Health and Therapeutic Support Services	Arden Shore Child Family Service - Mental Health Collaborative
Eric	Guenther	Police Chief	Mundelein Police Department
Eric	Foote	Community Development Planner/Grant Administrator Specialist	Lake County Government
Gail	Weil	Executive Director	Community Youth Network
Harry	Kromer	Director of Information Systems	Advocate Condell Medical Center
Janelle	Moravek	Executive Director	Youth and Family Counseling
Jennifer	Harris	President	CR Search Inc.
Jennifer	Serino	Director Workforce Development Department	Workforce Development Department
Jesse	Peterson Hall	President Highland Park Hospital	Highland Park Hospital (Northshore University Health System)
Jim	McFatrige	Sr. Director, EMR IT Operations	Thresholds
Jodi	Gingiss	Administrator	Community Development

Joel	Williams	Executive Director	PADS
John	Wurl	Manager, HIE Interface	Thresholds
Kathy	Pierson	Steering Team	Lake County United
Keith	Kaiser	Sgt. and Director of Training	Lake County Sherriff Office
Kim	Needham	Assistant CEO for Vista Health System	Quorum Health/Vista Health System
Lee	Francis	President and CEO	Erie Family Health Center
Linda	Snelton	Chief Operating Officer	NICASA
Lonnie	Renda	Director of Information Technology	Lake County State's Attorney Office
Loretta	Dorn	Chief Operations Officer	Lake County Health Department
Lorrie	George-Baskin	Director of Development	NICASA
Mark	Curren	Sheriff	Lake County Sherriff Office
Mark	Pfister	Executive Director Lake County Health Department	Lake County Health Department
Mary	Hillard	Vice President	Advocate Condell Medical Center
Mary	Jouppi	President	NAMI Lake County
Mary Ellen	Tamasy	President	Lake County Residential Development Corporation (LCRDC)
Megan	Powell-Filler	Deputy Director, Chair of the System Coordination & Entry Committee	Additional Housing Contact
Michelle	Vance	Clinical Nurse Manager	NorthShore University Health System
Mike	Hartman	Director of Information Technology and Telecommunications	Quorum Health/Vista Health System
Nick	Caputa	Program Coordinator Child and Adolescent Behavioral Health Services	Lake County Government
Norman	Stephens	Interim CEO	Quorum Health/Vista Health System
Pam	Cairns	President	Leading Healthy Futures
Posh	Charles	Director External Affairs and Community Health	Northwestern Memorial Healthcare
Rachel	Greenspan	Director, Medical Group Operations, Psychiatry	NorthShore Medical Group
Raman	Jathar	Data Architect	NorthShore University Health System
Rose	Gray	Director of Adult Probation	Lake County Circuit Court
Roxanne	Garza	Probation Officer	Lake County Circuit Court
Rudy	Martin	Probation Officer	Lake County Circuit Court
Sam	Johnson Murello	Associate Director Behavioral Health	Lake County Health Department
Steve	Fabbri	Assistant Director of Lake County Specialty Courts, Surveillance and IPS	Lake County Circuit Court
Steve	Husak	Police Chief	Lake Zurich Police Department
Steve	Balinski	Police Chief	Kildeer Police Department
Tilisha	Harrison	Senior Director of Mental Health	NICASA
Tina	Johnston	Probation Officer	Lake County Circuit Court
Vicky	Tello	VP of Operations	Arden Shore Child Family Service - Mental Health Collaborative

Winnie	Webber	IT Director	Lake County Circuit Court
Yareli	Facundo	Administrative Assistance at Cool Learning Experience	Lake County Health Department

Lake County Mental Health Coalition Facilitation:  
Current Data Sharing Assessment

**Objective:** To research the current data sharing practices across representative entities within Lake County to understand the strengths and weaknesses within the functional practices and technical capabilities with sharing data. The purpose of this research is to inform a future state data sharing framework in which organizations involved with mental, emotional, and behavioral health can recognize improved care coordination and better results for the individuals in the system through data sharing.

The purpose of the interviews are to understand and document the current state of:

- Care coordination between system partners
- Data / information shared during care coordination
- Data available for reporting
- Technological systems used

	Type of Question	
	Technical Question	Functional Question

#	Stakeholder Questions	Technical Question	Functional Question	Answer
	Name			
	Company			
	Title			
	<b>PROCESS</b>			
1.00	How do you determine the individuals need for behavioral health services and severity of need?		X	
2.00	What other organizations does your organization coordinate for referral and care coordination?		X	
3.00	What is the benefit to you for coordinating with these organizations?		X	
4.00	Are you able to attain access the behavioral health care on behalf the individuals you serve need		X	
5.00	What would help to improve access and timeliness		X	
6.00	Are there any measurements for the timeliness of that access		X	
7.00	Once you refer someone to a behavioral health service, do you have a need for on going coordination?		X	
8.00	What does that care coordination look like today		X	
9.00	If so, what would the ideal level of care coordination look?		X	
10.00	Are there any written instructions, requirements about how to collaborate or coordinate care between your organizations?		X	
11.00	If yes,		X	
12.00	May we receive a copy		X	
13.00	what are the documents		X	
14.00	What information is outlined in the documents?		X	
15.00	Scale 1 to 10 – 1 being not effective at all, 10 being most effective, how would you rate the effectiveness of the coordination between your organizations		X	
16.00	What two actions would improve your effectiveness in coordinating care?		X	
18.00	Lake County Mental Health Coalition concepts include a "No wrong door mentality"- what pain points do you find in facilitating individuals entry into the system?		X	
19.00	Lake County Mental Health Coalition concepts includes the idea that "individuals access care at the least restrictive appropriate setting" - what is your experince with this?		X	
20.00	Lake County Mental Health Coalition concepts/vision incudes that "outcomes are measured at the individual, provider and services system level" - what measures would you propose for a go forward strategy?		X	
	<b>DATA SHARING (Only If sharing data)</b>			
	<b>Data collected from participant</b>			
21	Does your organization have an electronic system to capture your service delivery with your clients?		X	
22	If no, how do you capture this information?	X	X	
23	If yes, what is the name of the system?	X	X	
24	What types of data you collect from the individual?	X	X	
25	What data element do you use to identify an individual?	X	X	
26	What is the language (code) you use to document behavioral health service need? (i.e. ICD 10)	X	X	
27	Do you document or have : Demographic, severity/risk, service notes, census, transfer information, encounter/service codes, cost data?	X	X	
28	Who is responsible for entering the data?	X	X	
29	Who if any is the data analyst who analyzes the data?	X	X	
	<b>Sharing (Data Sent to others)</b>			
30	Do you have data sharing agreements with any organizations within Lake County?	X	X	
31	If yes, may we have a copy?	X	X	
32	What data is shared when coordinating care?	X	X	
33	How do you verify that you are ALLOWED to share patient data with another entity?	X	X	
34	Who is responsible for sending the data?	X	X	
35	Any organization you do not share data with – why?	X	X	
36	Which organizations do <u>you send</u> data to?	X	X	

Lake County Mental Health Coalition Facilitation:  
Current Data Sharing Assessment

37	What data points do <u>you send</u> ?	X	X	
38	How is that data sent?	X	X	
<b>Receive (Data received from others)</b>				
39	Does your organization receive any reports from other system partner organizations?	X	X	
40	Which organizations <u>send you</u> information?	X	X	
41	What data points do you <u>receive</u> ?	X	X	
42	How is that data <u>sent</u> ?	X	X	
43	What data do you want but are not getting? How would this help you? Why are you not getting it?	X	X	
44	Can we have a sample of what is provided?	X	X	
<b>OTHER</b>				
45	What data do you aggregate?	X	X	
46	Do those reports include information on the availability or timeliness of services?	X	X	
47	May we have a copy?	X	X	
48	Does your organization have any current initiatives (planned or under way) regarding data collection or data system enhancements for the purpose of care coordination?	X	X	
49	If yes, please describe the initiative and the goals	X	X	
50	Have there been any past attempts to improve coordination and data shared? Describe them.	X	X	
51	Do you have any recommendations about how to improve how data is shared?	X	X	
52	Do you have a Chief Security/Privacy Officer?	X		
53	If yes, who is it?	X		
54	Do you have a standard set of privacy/security policies?	X		
55	May we have a copy of it?	X		
56	How do you assess the availability of subsequent services on behalf of the individual with mental health needs? Availability may also refer to the lack of services available. If this is a calculation please indicate the formula or who can share the formula with us.	X	X	
57	What data points do you use to measure the care coordination with your organization? Do you have any data that you can share?	X	X	
58	What Key Performance Metrics are you measured by as it pertains to Individuals with mental health needs?	X	X	
<b>TECHNICAL</b>				
59	Describe your role within the organization?	X		
60	What are the primary business areas that you support and what are the main types of information / data in your systems? (Patient, etc.?)	X		
61	Are the data for your systems maintained within your organization or are they maintained outside of your organization by a 3 <sup>rd</sup> party?	X		
62	Do you have access and ownership to all of the detailed data within your systems?	X		
63	Do you have logical data flows and logical data diagrams of data within your systems?	X		
64	Do you have a medical billing/claims system? If so, which one?	X		
65	Do you submit your claims (837's) to a central exchange? If so, which one?	X		
66	Do you have a Electronic Medical Record (EMR)/Electronic Health Record (HER) system? If so, which one?	X		
67	What other system(s) do you have that contain patient/individual information?	X		
68	Do you send out Admit/Discharge/Transfer (ADT's) messages? If so, to who? Using what method (HL7, CCDA, etc.)?	X		
69	Do you currently participate in a Health Information Exchange (HIE)? If so, which ones? Which of your systems are connected to that HIE?	X		
70	Do you currently exchange information with other organizations? (What information do you send? What information do you receive?)	X		
71	How do you exchange information with other organizations outside of your organization? How do you send information? How do you receive information? (E.g., Service Oriented Architecture, email, manual, etc.),	X		
72	How old/current is the data when you share or receive with other organizations?	X		
73	Do you archive some of your data? Is this data retrievable for reporting or sharing?	X		
74	At what level of detail is the information that you share or receive? (Aggregated information or detail level of information?	X		
75	Do you have separate systems for reporting and analytics? (E.g., Data Warehouse Systems)	X		
76	On what database platform(s) do your operational systems reside? (Oracle, MS SQL Server, Etc.)	X		
77	On what database platform(s) do your analytical systems reside? (Oracle, MS SQL Server, Etc.)	X		
78	How would you rank the quality of data within your organization? (Excellent, Average, Poor)	X		
79	What is the granularity of data that is maintained and shared?	X		
80	How do you apply security to your information / data? At the database or application level?	X		
81	Do you store PII (Personally identifiable information) data in your systems? What are some examples of this PII data? Is all of this data HIPAA related?	X		
82	What data elements do you use to identify an individual?	X		
83	Do you use a secure messaging (email, text, etc.) system within your organization? External to your organization?	X		
84	How do you verify that you are ALLOWED to share patient data with another entity?	X		
85	Do you have any data sharing agreements in place? With which organizations?	X		

Lake County Mental Health Coalition Facilitation:  
Current Data Sharing Assessment

86	Do you have a Chief Security/Privacy Officer?	X		
87	Are there any Data Governance initiatives currently in place?	X		
88	tools?	X		
89	What are the current IT initiatives and priorities in your area? What significant projects are upcoming that may impact data sharing, e.g. systems that are: New Systems, Systems Being Replaced, Systems in Decline.	X		
<b>BARRIERS TO DATA SHARING</b>				
90	Why do you not share data?	X	X	
91	What is the legal reason for not sharing data?	X	X	
92	Other than legal, are there other process barriers to sharing data?	X	X	
93	Are there technical barriers that prevent data sharing?	X	X	
94	Are there political reasons for not sharing data?	X	X	
95	Are there proprietary/competitive reasons for not sharing data?	X	X	
96	Is there is reason for not sharing information / data? Explore deeper based on response.	X	X	
97	Do you see potential value in sharing information/data?	X	X	
98	If yes, explore value and what barriers exist for not sharing data.	X	X	
99	If no, what would need to change for it to add value for you?	X	X	

**Public Awareness Campaign**

100	A barrier to individuals accessing the services they need is the stigma around mental, emotional and behavioral health. Lake County has an opportunity as a community to change that perception. If Lake County were to support a campaign, how do you see your organization taking part in the campaign? (Funding, profile identification, resources, message creation, process/inserts)		X	
-----	---	--	---	--

<b>WRAP UP</b>				
101	Do you have any other thoughts pertaining to this topic that you would like to share?	X	X	

## Appendix 7.5: Excerpts from the Illinois HHS Medicaid Waiver Advisory committee discussions

The following are from slides from the Illinois HHS Medicaid Waiver Advisory Committee Discussion discussion document.



### Health and Human Services Transformation

## Illinois HHS Medicaid Waiver Advisory Committee Discussion

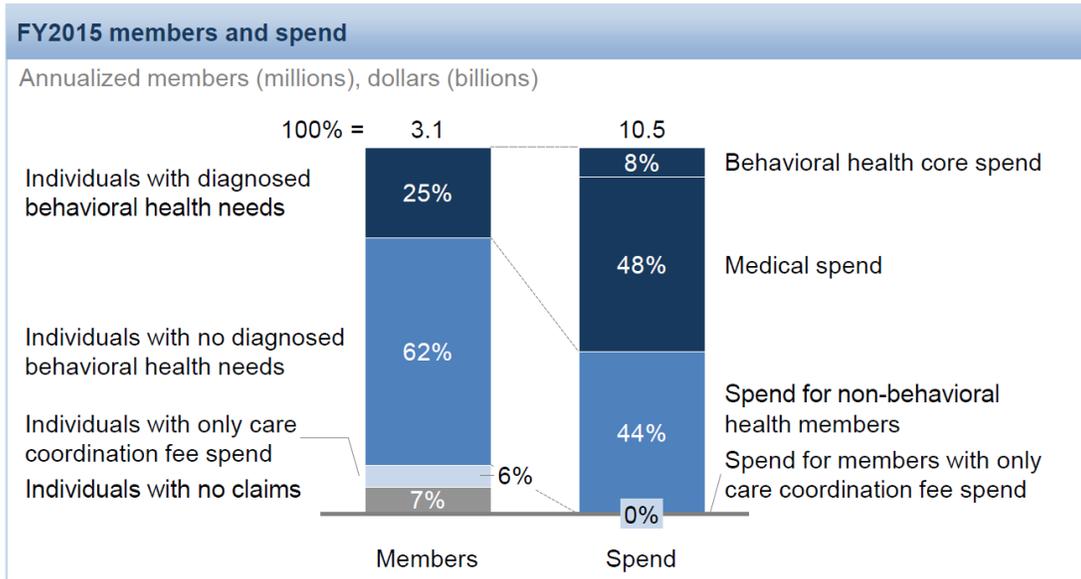
Discussion document

January 19, 2017

## Appendix 7.5: Excerpts from the Illinois HHS Medicaid Waiver Advisory committee discussions

DRAFT - Confidential and Proprietary

**Medicaid individuals with diagnosed behavioral health needs make up ~25% of the population, but ~56% of the total spend**

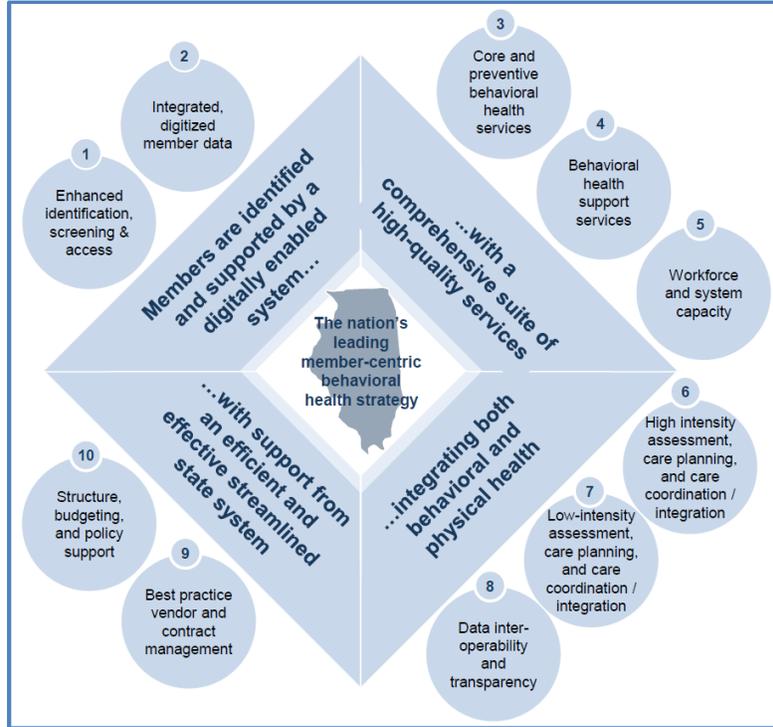


SOURCE: FY15 State of Illinois DHFS claims data

## Appendix 7.5: Excerpts from the Illinois HHS Medicaid Waiver Advisory committee discussions

DRAFT - Confidential and Proprietary

### Objectives of the Illinois HHS Transformation to address these challenges

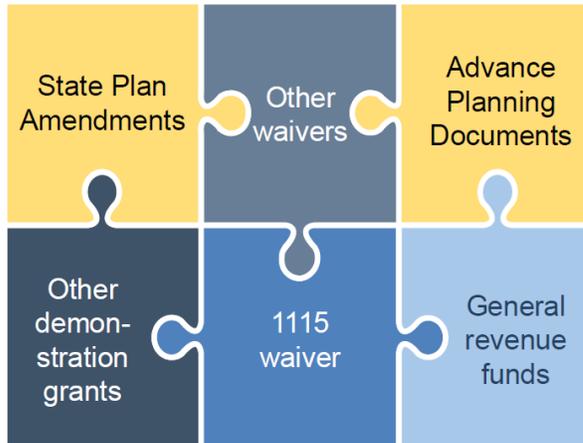


## Appendix 7.5: Excerpts from the Illinois HHS Medicaid Waiver Advisory committee discussions

DRAFT - Confidential and Proprietary

### The State will also pursue initiatives outside the waiver to advance its behavioral health strategy

■ Non-waiver initiatives covered here



#### Other initiatives

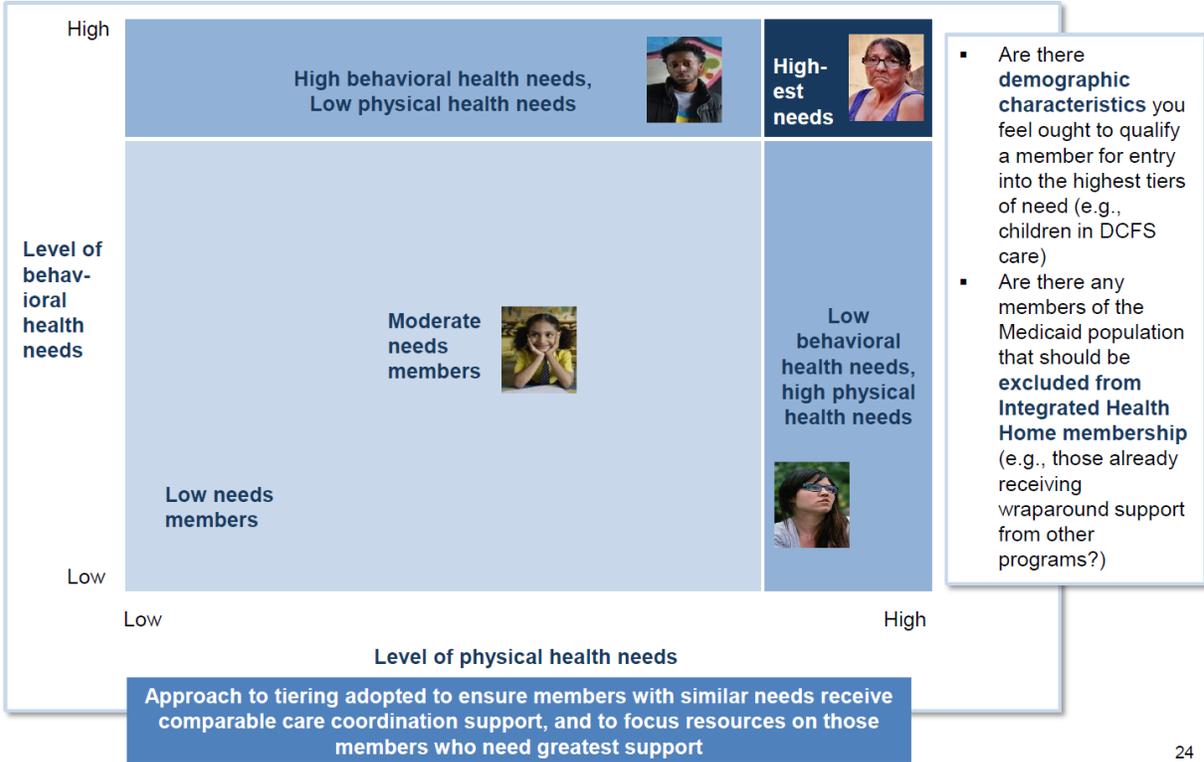
- State Plan Amendments (SPAs), including, but not limited to:
  - Integrated physical and behavioral health homes
  - Crisis stabilization and mobile crisis response
  - Medication-assisted treatment (MAT)
  - Uniform Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA)
- Advance Planning Documents (APDs)
  - Data interoperability through 360-degree view of behavioral health member

## Appendix 7.5: Excerpts from the Illinois HHS Medicaid Waiver Advisory committee discussions

DRAFT - Confidential and Proprietary

### 1 Member inclusion and engagement: Introduction to suggested approach

ILLUSTRATIVE



## Appendix 7.6: Public Awareness Campaign Socialization

### Public Awareness Campaign Socialization

Data Sharing is one of the Coalition’s initiatives as outlined in their charter. Another task the Coalition has discussed is a public awareness campaign. North Highland explained the purpose behind a public awareness campaign, potential approaches and asked for a description of interviewee’s potential participation in a public awareness campaign in every interview to begin socializing this initiative on behalf of the Coalition. Messages were framed using the respective sector’s “What’s in it for me” messaging and tailored per organization based on the needs and anecdotal stories shared during the technical and functional interviews.

Communicating the below goals of the public awareness campaign in particular resulted in improved enthusiasm for the campaign:

- Encouraging people to access care, particularly those not already accessing services
- Overcoming the stigma of behavioral health
- Equipping behavioral health individuals and families with the information needed to get services

	HEALTHCARE 	JUSTICE SYSTEM 	COMMUNITY 
Key Messages	<ul style="list-style-type: none"> <li>• Mitigating misuse of ED resources and increasing use of less acute settings to treat less acute cases</li> <li>• With more individuals accessing services, the data available on the real need across the Lake County and across services will improve.</li> </ul>	<ul style="list-style-type: none"> <li>• Jail diversion</li> <li>• Less calls to police and more to the appropriate service provider for behavioral health incidents</li> </ul>	<p>The ability to address needs earlier so health issues have less of a compounding impact on societal factors of health, such as maintaining employment and stable housing</p>
Communicated Concerns	<p>Would need to get approval and see whether messaging is aligned with their internal marketing</p>	<p>Needs to be a combined effort across agencies to be effective</p>	<p>Would need to prepare to ramp up organizations to support an increased demand</p>

# User Policy, Responsibility Statement & Code of Ethics

---

*For Lake County's ServicePoint®*

## User Policy

Partner Agencies shall share information for the purposes of coordinating services to individuals enrolled in ServicePoint®. Aggregate non-identifying data may also be used for reporting unduplicated counts to state, federal and other funding sources. Lake County seeks to establish a uniform, consistent, and accurate source of data for all member participants and stakeholders.

It is a Client's decision about which information, if any, entered into the ServicePoint® system shall be shared and with which Partner Agencies. The *Consent To Use ServicePoint®* must be signed if the Client agrees to share basic information with Partner Agencies. A separate *Release of Information* form must be signed if the Client agrees to share anything other than basic identifying information.

**The ServicePoint® system is a tool to assist agencies in focusing services and locating alternative resources to help clients. Therefore, agency staff should use the Client information in the ServicePoint® system to target services to the Clients' needs.**

To the greatest extent possible, data necessary for the development of aggregate reports of homeless services, including services needed, services provided, referrals and client goals and outcomes should be entered into the system in a timely and accurate manner.

## Users Code of Ethics

- A. The ServicePoint User has primary responsibility for his/her Client(s).
- B. Each ServicePoint User should maintain high standards of professional conduct in the capacity as a ServicePoint User.
- C. ServicePoint Users must treat Partner Agencies with respect, fairness and good faith.
- D. ServicePoint Users have the responsibility to relate to the Clients of other Partner Agencies with full professional consideration.

## Strong Password Protocols

Minimum length of eight characters which:

- Are not based on anything somebody else could easily guess or obtain using person related information, e.g. names, telephone numbers, dates of birth, etc.
- Are free of consecutive identical characters or all-numeric or all-alphabetical groups
- Are free of word or number patterns
- Are not names or words in any dictionary including English, foreign languages, and technical dictionaries (legal, medical, etc.)
- Contains at least one uppercase letter, one lowercase letter, and 2 numbers

## User Responsibility

Your User ID and Password give you access to the Lake County ServicePoint® system. **Initial each item below to indicate your understanding and acceptance of the proper use of your User ID and password.**

Failure to uphold the confidentiality standards set forth below is grounds for immediate termination from the ServicePoint® system.

- My User ID and Password are for my use only and must not be shared with anyone.
- I must take all reasonable means to keep my password physically secure.
- I understand that the only individuals who can view information in the ServicePoint system are authorized users and the Clients to whom the information pertains.
- I may only view, obtain, disclose, or use the database information that is necessary to perform my job.
- I am required to understand and obey all requirements indicated in the *Service Point® Business Agreement* and *Notice of Privacy Practices*.
- Each client must be informed of their privacy rights and sign the *Consent to Use ServicePoint®* before their information is entered in to the database.
- Client information will only be shared in a manner consistent with the signed consents and releases of information by the client.
- If I am logged Into ServicePoint® and must leave the work area where the computer is located, I **must log-off** of ServicePoint® before leaving the work area.
- A computer that has ServicePoint® open and running shall never be left unattended.
- Failure to log off ServicePoint® appropriately may result in a breach in client confidentiality and system security.
- Hard copies of ServicePoint® information must be kept in a secure file.
- When hard copies of ServicePoint® information are no longer needed, they must be properly destroyed to maintain confidentiality.
- If I notice or suspect a security breach, I must immediately notify the Agency Administrator for ServicePoint® or the Lake County System Administrator at 847-377-2331.

**I understand and agree to comply with all the statements listed above.**

\_\_\_\_\_  
ServicePoint User – **Print Name & Sign** \_\_\_\_\_  
Date

\_\_\_\_\_  
Agency Administrator – **Print Name & Sign** \_\_\_\_\_  
Date

*Note: Forms should be signed by the User & Agency Administrator, a copy kept on site and a copy delivered to the Lake County ServicePoint Administrator.*

**PATIENT AUTHORIZATION FORM FOR DISCLOSURE OF HEALTH INFORMATION AND/OR BEHAVIORAL HEALTH INFORMATION**

\*\*\*PLEASE READ THE ENTIRE FORM, ALL FIVE PAGES, BEFORE SIGNING BELOW\*\*\*

**Information of person whose health information is being disclosed:**

Name (First Middle Last): \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

South Florida Behavioral Health Network (SFBHN) has developed a coordinated system of care to provide behavioral health (mental health and substance abuse) treatment services. This care is provided through entities that are part of SFBHN's Network of Providers. To promote quality of care and efficient and coordinated services, as well as to communicate with the Florida Department of Children & Families (DCF) and the Florida Medicaid Program to obtain payment for your care, SFBHN must be able to share certain information about you with members of its Network and others that help SFBHN operate. Please read this form, and let us know whether you give permission for us to share your information for these purposes.

By signing this form, you are voluntarily giving your permission to allow the use and disclosure (including paper, oral, and electronic sharing):

**OF WHAT: ALL MY HEALTH INFORMATION, including information about sensitive conditions (if any).**

This includes health information created before or after the date I signed this form. Health information includes, but is not limited to, my demographic information (name, address, date of birth, Social Security Number, race/ethnicity), and location of intake, treatment site and case management. It includes all records and other information regarding my health history, treatment, hospitalization, tests, residential and outpatient care, including medical history, physical exams and test results. This also includes my specific permission to release any and all of the following information:

- a. Drug, alcohol, or substance abuse;
- b. Psychological, psychiatric or other mental impairment(s), mental condition or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501);
- c. Sickle cell anemia;
- d. Birth control and family planning;
- e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis;
- f. Genetic (inherited) diseases or tests.

Additionally, Medicaid eligibility information may be shared with SFBHN.

**FROM WHOM: All information sources.**

This includes, but is not limited to, medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and Veterans Affairs health care facilities, state registries and other state programs, social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, the Florida Department of Children and Families, state Medicaid, Medicare and any other governmental program.

**TO WHOM: (please check one)**

NOTE: Your basic demographic information (name, address, year of birth, and last four digits of social security number) may still be shared with network providers, SFBHN and its business associates, service providers, and payors listed in Attachment I to facilitate SFBHN operations. It will also be visible in the consumer search screen.

SFBHN its payors, trusted business associates, and service providers and ALL participating Network Providers of South Florida Behavioral Health Network listed in Attachment I.

ONLY SFBHN and my current SFBHN treating Provider.

Current Treating Provider Name: \_\_\_\_\_ Phone: ( \_\_\_\_\_ )

Address: \_\_\_\_\_ Fax: ( \_\_\_\_\_ )

SFBHN, my current SFBHN treating Provider, AND the specific organization(s) permitted to receive my information as listed below.

Current Treating Provider Name: \_\_\_\_\_ Phone: ( \_\_\_\_\_ )

Address: \_\_\_\_\_ Fax: ( \_\_\_\_\_ )

Person/Organization Name: \_\_\_\_\_ Phone: ( \_\_\_\_\_ )

Address: \_\_\_\_\_ Fax: ( \_\_\_\_\_ )

Person/Organization Name: \_\_\_\_\_ Phone: ( \_\_\_\_\_ )

Address: \_\_\_\_\_ Fax: ( \_\_\_\_\_ )

Person/Organization Name: \_\_\_\_\_ Phone: ( \_\_\_\_\_ )

Address: \_\_\_\_\_ Fax: ( \_\_\_\_\_ )

Please use the back of the form to identify additional providers.

**PURPOSE:** To allow access to your information as needed for the following (see page 4 of this form for more information):

- To provide you with medical treatment
- To obtain payment for your care
- For health care operations purposes, including disclosures to business associates
- To provide you with treatment-related services and products
- To make it easier to coordinate your care and schedule follow up services
- To evaluate and improve patient safety and the quality of medical care provided to all patients
- To create de-identified information to be used for any lawful purpose
- To create limited data sets to be used for research, public health, or health care operations
- To create aggregated data reports for group statistical research and analysis. The research and analysis will not contain any information that could be used to contact or identify you

**Note: If you have not allowed full access to your information:**

1. You may not be able to receive certain care coordination services, which require the sharing of your information; and
2. Your demographic information will still be shared with SFBHN and its business associates, service providers and payors. Your basic demographic information will also be visible in the consumer search screen.

**EFFECTIVE PERIOD:** This authorization/permission form will remain in effect until the day you withdraw your permission, the date of your death, or one year from the date signed below, whichever is sooner.

**REVOKING YOUR PERMISSION:** Your consent can be revoked at any time except to the extent that the organization which is to make the disclosure, has already taken action in reliance on it. You can revoke your permission at any time by giving written notice to the person or organization to which you originally gave this form.

**EFFECT OF REVOCATION OR EXPIRATION:** Even if your consent expires or is withdrawn, you will still be able to receive services from SFBHN. Revocation or expiration of your permission will not affect actions taken while your permission was in effect. If your information can no longer be shared, it will affect your ability to take full advantage of care coordination services provided by SFBHN.

**PHOTOGRAPHIC CONSENT AND RELEASE:**

You acknowledge that you have been advised that a photograph will be taken of you for the purpose of assisting in your care, documenting your treatment for payment reasons, and assisting in health care operations.

Please initial one of the following:

\_\_\_\_\_ I consent to have my photograph taken and shared with South Florida Behavioral Health Network, its Network Providers, and its trusted business associates and service providers. I authorize the release of my image for the purposes explained in this form. I understand that my most recent photograph will be shared in the SFBHN system.

\_\_\_\_\_ I do not consent to have my photograph taken.

**AGREEMENT:**

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be disclosed to other parties, like SFBHN's business associates, service providers and payors , and other network providers (see page 4 for details).
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures specified above from the sources listed.**

**X** \_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date Signed (mm/dd/yyyy)

**X** \_\_\_\_\_  
Signature of Patient's Legal Representative (if applicable)

\_\_\_\_\_  
Date Signed (mm/dd/yyyy)

\_\_\_\_\_  
Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- Parent of minor
- Legal Guardian
- Other personal representative (explain: \_\_\_\_\_)

**This form shall be valid for 12 months unless revoked as indicated in the "Effective Period" section above.  
You are entitled to get a copy of this form.**

## Explanation of "Patient Authorization Form for Disclosure of Health Information"

### PLEASE READ AND INITIAL THIS PAGE BELOW

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions.

Why Your Information is Used and Disclosed: The South Florida Behavioral Health Network (SFBHN) works with the Florida Department of Children and Families to administer and manage a coordinated system of care for adults and children. The SFBHN Providers need to exchange information with each other to better manage your care. Trusted business associates and service providers of SFBHN are working to develop ways to better coordinate care and to improve quality and outcomes. As part of its efforts, these trusted business associates and service providers have developed utilization management software that is used by SFBHN and the Providers in its network. The business associates and service providers use and analyze de-identified information from that system for statistical research and analysis. Anything that identifies you will be removed from the information. This de-identified information will also be used by the trusted business associates and service providers to develop new commercial products.

Definitions: In this form, the term "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR §§ 160.103 and 164.501).

#### "To Whom":

- If you specified a healthcare provider in the "TO WHOM" section above, this permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates, subcontractors or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified.
- If you specified an organization other than a healthcare provider in the "TO WHOM" section above, this permission would also include that organization's staff or agents, business associates and subcontractors who carry out activities and purpose(s) permitted by this form for that organization that you specified.

Revocation: You have the right to revoke this authorization and withdraw your permission at any time regarding future uses by giving written notice. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

Re-disclosure of Information: Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources.

---

Initials

Attachment I

**South Florida Behavioral Health Network Providers**

Banyan Health Systems, Inc.  
Behavioral Science Research Institute, Inc.  
Better Way of Miami, Inc.  
Camillus House, Inc.  
Catholic Charities of The Archdiocese of Miami, Inc.  
Citrus Health Network, Inc.  
Community AIDS Resource, Inc. (d.b.a.) CARE Resource  
Community Health of South Florida Inc. (CHI)  
Concept Health Systems, Inc.  
Douglas Gardens Community Mental Health Center of Miami Beach, Inc.  
Family & Children Faith Coalition, Inc. d/b/a Hope for Miami  
Federation of Families/ Miami-Dade Chapter, Inc.  
Fresh Start of Miami-Dade, Inc.  
Gang Alternative, Inc.  
Guidance Care Center, Inc. (GCC)  
Here's Help, Inc.  
Institute for Child and Family Health, Inc. (ICFH)  
Jessie Trice Community Health Center, Inc.  
Key West HMA LLC (d.b.a.) Lower Keys Medical Center  
King David Foundation, Inc./CLAPA  
MDC-Community Action and Human Services Dept. (MDC-CAHSD)  
Miami-Dade County Juvenile Services Department (MD-JSD)  
Miami-Dade Homeless Trust (MDHT)  
Monroe County Coalition, Inc.  
New Hope CORPS, Inc.  
New Hope Drop-In Center, Inc.  
New Horizons Community Mental Health Center, Inc.  
Passageway Residence of Dade County, Inc.  
Psychosocial Rehabilitation Center, Inc., d.b.a, Fellowship House  
Public Health Trust of Miami-Dade County, Florida (PHT)  
South Florida Jail Ministries, Inc. (d.b.a.) Agape Family Ministries  
Switchboard of Miami, Inc.  
The Center for Family and Child Enrichment, Inc. (CFCE)  
The Key Clubhouse of South Florida, Inc.  
The Miami Coalition For a Safe and Drug-Free Community, Inc.  
The Village South, Inc.

**NOTE:** SFBHN's business associates include, but may not be limited to, IBM Global Business Services and Otsuka America Pharmaceutical, Inc. SFBHN also has service providers, such as FireHost and CapGemini. SFBHN's payors include Florida Department of Children and Families and the Florida Medicaid Program.



RECEIVED

JAN 07 2016

MEMORANDUM OF AGREEMENT  
AMONG  
COMMUNITY REACH CENTER  
ADAMS COUNTY SHERIFF'S OFFICE  
AND  
ADAMS COUNTY CRIMINAL JUSTICE COORDINATING COMMITTEE

Agreement made among the Community Reach Center (hereinafter referred to as CRC), acting by its Chief Executive Officer, the Adams County Sheriff's Office (hereinafter referred to as ACSO), acting by its Sheriff, and the Adams County Criminal Justice Coordinating Committee (hereinafter referred to as CJCC), acting by its Chairman.

WHEREAS, Title 42, Code of Federal Regulations, Part 2 provides federal regulations governing the confidentiality and disclosure of Alcohol and Drug Abuse Patient Records for individuals receiving substance abuse treatment; and,

WHEREAS, the Health Insurance Portability and Accountability Act, Title 45, Code of Federal Regulations Parts 160, General Administrative Requirements, 162, Administrative Requirements and 164, Security and Privacy establish regulations governing the confidentiality and disclosure of Protected Health Information, including that the release of psychotherapy notes must be requested on a separate form from any other health information; and,

WHEREAS, to facilitate the sharing of substance use, behavioral health, and criminal justice information, in compliance with federal and state laws and regulations; and,

WHEREAS, CRC, ACSO and CJCC have identified the sharing of behavioral health and substance use information in the custody and control of CRC and ACSO, as important to the coordination of quality care for individuals treated in the various Adams County criminal justice agencies and behavioral health care system; and,

WHEREAS, the CJCC was competitively selected by the Open Justice Broker Consortium (OJBC), to develop analytic capabilities (for strategic decision-making) beyond the federated query portal (for tactical decision-making) currently being developed by OJBC; and,

WHEREAS, OJBC received a grant from the Laura and John Arnold Foundation to develop this capability for three states or local jurisdictions; and,

WHEREAS, CRC, ACSO and CJCC agree a "data store" is defined as a repository for storing and managing data sets on an enterprise level; and,

WHEREAS, CRC, ACSO and CJCC agree a "dashboard" is defined as an easy to read, real-time user interface, showing a graphical presentation of the current status (snapshot) and historical trends of key performance indicators to enable instantaneous and informed strategic decisions to be made at-a-glance; and,

WHEREAS, CRC, ACSO and CJCC desire to create a data store and related dashboards to enable interagency data sharing in order to:

- Develop lawful and effective justice and behavioral health information exchanges between and among law enforcement, criminal and juvenile justice, health and mental health providers, human/social services agencies, including substance abuse treatment agencies, and other government and community organizations that desire amonized level data to ensure continuity of care and to apply resources based on evidence; and,
- To support the administration of justice, public safety, and public policy decisions across key decision points with local, state, and national agencies; and,
- Improve collaboration and information sharing between justice and health systems within Adams County; and,
- Ensure immediate availability of complete, accurate and timely data and information for quality decision-making, reporting, analysis and research; and,
- Build upon, leverage and enhance the existing criminal justice information systems currently deployed by each Member; and,
- Use best practices and adopt the use of national justice information sharing standards (e.g. NIEM, GRA, GFIPM), where applicable; and,
- Reduce recidivism by helping to ensure that offenders – whether in a community or incarceration setting – receive educational, vocational, rehabilitation and/or treatment services matched to evidence; and,
- Improve and sustain continuity in services provided to offenders as they move between arrest and re-entry.

WHEREAS, each party agrees to participate in periodic meetings of all parties, not less than quarterly, for the purpose of reviewing the status of the development and implementation of dashboard(s) under the auspices of this agreement. Special meetings may be convened at the request of any party based upon changes in federal and/or state laws or regulations.

Now, therefore be it resolved, that CRC, ACSO and CJCC agree:

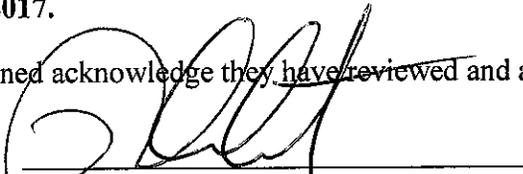
- To develop a Project Charter that outlines business rules, policies, procedures, regulations or standards that describe each agency's role and responsibility relative to sharing information to ensure continuity of care for persons in need of behavioral health and substance abuse treatment services; and,
- To build a web-based application to access one or more dashboards that allows for distributed user management. The system must allow authorized users to login to the web-based application using credentials supplied by the user's "native" agency – i.e. no agency will be required to provision new credentials to use the system; and,
- The system must define and enforce rules for access to ensure that individuals only access that information to which they are authorized; and,
- The system must maintain query and search response transaction logs sufficient to allow for audit and investigation capability; and,

- The data store must be secured to prevent inappropriate access and prevent intrusions; and,
- The data store must not capture or contain Personal Identifiable Information (PII) or Personal Health Information (PHI); and,
- The application must allow consumers with appropriate permission to access and analyze aggregate data; and,
- Ensure that agency personnel and appropriate contractual staff participate in cross-training or educational events to improve each agency's knowledge and understanding of Adams County's criminal justice and behavioral systems' roles and responsibilities.

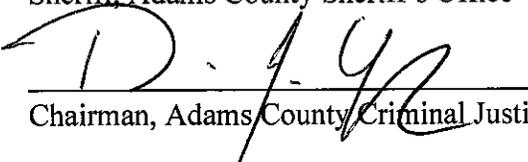
This Agreement may be modified only by a written document that is signed by the duly authorized representatives of any involved parties. Any party may withdraw from this Agreement after giving thirty (30) days written notice to all other parties. The thirty (30) day notice provision will not apply if, in the opinion of a signatory to this Agreement, the health, welfare or safety of the public, the staff of any signatory, or clients is in jeopardy. In such case, written notice of the termination will be forwarded to each other party and will set forth the reasons why the health, welfare or safety of the public, the staff of any signatory, or clients was jeopardized and be effective immediately.

**This Agreement is effective for one year beginning on January 8, 2016 and effective to January 8, 2017.**

The undersigned acknowledge they have reviewed and agree to this MOA.

Signature:  Date: 12/28/15  
 Name/Title: Chief Executive Officer, Community Reach Center

Signature:  Date: 01/11/16  
 Name/Title: Sheriff, Adams County Sheriff's Office

Signature:  Date: 1/15/16  
 Name/Title: Chairman, Adams County Criminal Justice Coordinating Committee

## County Police Access to DHS Data

Allegheny County Department of Human Services (DHS)  
9/23/2016 (revised: 10/25/2016)

### Summary

This document discusses what DHS client information may be shared with law enforcement to support enforcement activities. It considers HIPAA's privacy rule, the PA substance abuse regulations which in this instance preempt the federal substance abuse regulations, and the PA Mental Health Procedures Act. In general, all of these regulations preclude the sharing of health, mental health and substance abuse information without the client's consent. HIPAA provides a comprehensive list of exceptions for law enforcement. The substance abuse regulations and MH Procedures Act provide far fewer exceptions.

Based on these prevailing regulations, DHS believes it can share the following client information with law enforcement given the circumstances and limitations provided below:

1. Without client authorization, DHS can share name, address, date and place of birth, social security number, services provided (exact language is "type of injury;" MH and Substance Abuse prohibits this sharing), date and time of service for the purposes of identifying or locating a suspect, fugitive, material witness or missing person.
2. Without authorization to a law enforcement official reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public, DHS may provide a client's treatment information excluding Substance Abuse and Mental Health records.
3. With court order, or court ordered warrant, a subpoena or summons issued by a judicial officer or a grand jury subpoena, DHS may provide a client's treatment information excluding Substance Abuse (no exception) and Mental Health (Requires court order; subpoena and summons does not authorize release) records.
4. With victim's agreement or (without agreement for incapacitated victims as long as assurances are provided by law enforcement that the information will not be used against victim), DHS may share treatment information excluding Substance Abuse and Mental Health records.

### HIPAA – PHI Disclosure Allowances

The Rule permits covered entities to disclose protected health information (PHI) to law enforcement officials, without the individual's written authorization, under specific circumstances summarized below.

- **To comply with a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer, or a grand jury subpoena.** The Rule recognizes that the legal process in obtaining a court order and the secrecy of the grand jury process provides protections for the individual's private information (45 CFR 164.512(f)(1)(ii)(A)-(B)).
- **To respond to an administrative request, such as an administrative subpoena or investigative demand or other written request from a law enforcement official.** Because an administrative request may be made without judicial involvement, the Rule requires all administrative requests to include or be accompanied by a written statement that the

information requested is relevant and material, specific and limited in scope, and de-identified information cannot be used (45 CFR 164.512(f)(1)(ii)(C)).

- **To respond to a request for PHI for purposes of identifying or locating a suspect, fugitive, material witness or missing person; but the covered entity must limit disclosures** of PHI to name and address, date and place of birth, social security number, ABO blood type and rh factor, **type of injury**, date and time of treatment, date and time of death, and a description of distinguishing physical characteristics. Other information related to the individual's DNA, dental records, body fluid or tissue typing, samples, or analysis cannot be disclosed under this provision, but may be disclosed in response to a court order, warrant, or written administrative request (45 CFR 164.512(f)(2)).

**This same limited information may be reported to law enforcement:**

- **About a suspected perpetrator of a crime when the report is made by the victim who is a member of the covered entity's workforce** (45 CFR 164.502(j)(2));
- **To identify or apprehend an individual who has admitted participation in a violent crime** that the covered entity reasonably believes may have caused serious physical harm to a victim, provided that the admission was not made in the course of or based on the individual's request for therapy, counseling, or treatment related to the propensity to commit this type of violent act (45 CFR 164.512(j)(1)(ii)(A), (j)(2)-(3)).
- **To respond to a request for PHI about a victim of a crime, and the victim agrees.** If, because of an emergency or the person's incapacity, the individual cannot agree, the covered entity may disclose the PHI if law enforcement officials represent that the PHI is not intended to be used against the victim, is needed to determine whether another person broke the law, the investigation would be materially and adversely affected by waiting until the victim could agree, and the covered entity believes in its professional judgment that doing so is in the best interests of the individual whose information is requested (45 CFR 164.512(f)(3)).

Where child abuse victims or adult victims of abuse, neglect or domestic violence are concerned, other provisions of the Rule apply:

- **Child abuse or neglect may be reported** to any law enforcement official authorized by law to receive such reports and the agreement of the individual is not required (45 CFR 164.512(b)(1)(ii)).
- **Adult abuse, neglect, or domestic violence may be reported** to a law enforcement official authorized by law to receive such reports (45 CFR 164.512(c)):
  - If the individual agrees;
  - If the report is required by law; or
  - If expressly authorized by law, and based on the exercise of professional judgment, the report is necessary to prevent serious harm to the individual or others, or in certain other emergency situations (see 45 CFR 164.512(c)(1)(iii)(B)).
  - Notice to the individual of the report may be required (see 45 CFR 164.512(c)(2)).

- **To report PHI to law enforcement when required by law** to do so (45 CFR 164.512(f)(1)(i)). For example, state laws commonly require health care providers to report incidents of gunshot or stab wounds, or other violent injuries; and the Rule permits disclosures of PHI as necessary to comply with these laws.
- **To alert law enforcement to the death of the individual**, when there is a suspicion that death resulted from criminal conduct (45 CFR 164.512(f)(4)).
- Information about a decedent may also be shared with medical examiners or coroners to assist them in identifying the decedent, determining the cause of death, or to carry out their other authorized duties (45 CFR 164.512(g)(1)).
- **To report PHI that the covered entity in good faith believes to be evidence of a crime that occurred on the covered entity's premises** (45 CFR 164.512(f)(5)).
- **When responding to an off-site medical emergency, as necessary to alert law enforcement about criminal activity**, specifically, the commission and nature of the crime, the location of the crime or any victims, and the identity, description, and location of the perpetrator of the crime (45 CFR 164.512(f)(6)). This provision does not apply if the covered health care provider believes that the individual in need of the emergency medical care is the victim of abuse, neglect or domestic violence; see above Adult abuse, neglect, or domestic violence for when reports to law enforcement are allowed under 45 CFR 164.512(c).
- When consistent with applicable law and ethical standards
  - To a law enforcement official reasonably able to **prevent or lessen a serious and imminent threat to the health or safety of an individual or the public** (45 CFR 164.512(j)(1)(i)); or
  - **To identify or apprehend an individual who appears to have escaped from lawful custody** (45 CFR 164.512(j)(1)(ii)(B)).
- **For certain other specialized governmental law enforcement purposes**, such as:
  - **To federal officials authorized to conduct intelligence, counter-intelligence**, and other national security activities under the National Security Act (45 CFR 164.512(k)(2)) or to provide protective services to the President and others and conduct related investigations (45 CFR 164.512(k)(3));
  - **To respond to a request for PHI by a correctional institution or a law enforcement official having lawful custody of an inmate** or others if they represent such PHI is needed to provide health care to the individual; for the health and safety of the individual, other inmates, officers or employees of or others at a correctional institution or responsible for the transporting or transferring inmates; or for the administration and maintenance of the safety, security, and good order of the correctional facility, including law enforcement on the premises of the facility (45 CFR 164.512(k)(5)).

Except when required by law, the disclosures to law enforcement summarized above are subject to a minimum necessary determination by the covered entity (45 CFR 164.502(b), 164.514(d)). When reasonable to do so, the covered entity may rely upon the representations of the law enforcement official (as a public officer) as to what information is the minimum necessary for their lawful purpose (45 CFR 164.514(d)(3)(iii)(A)). Moreover, if the law enforcement official making the request for information is not known to the covered entity, the covered entity must verify the identity and authority of such person prior to disclosing the information (45 CFR 164.514(h)).

### **Substance Abuse Treatment Records**

§ 255.5. Projects and coordinating bodies: disclosure of client-oriented information.

(a) Disclosure. Information systems and reporting systems **shall not disclose or be used to disclose** client oriented data which reasonably may be utilized to identify the client to any person, agency, institution, governmental unit, or **law enforcement personnel**. Project staff may disclose client oriented data only under the following situations:

[No exception are provided for law enforcement personnel.]

### **PA Mental Health Procedures Act**

§ 5100.32. Nonconsensual release of information.

(a) Records concerning persons receiving or having received treatment shall be kept confidential and shall not be released nor their content disclosed without the consent of a person given under § 5100.34 (relating to consensual release to third parties), except that relevant portions or summaries may be released or copied as follows:

- (1) To those actively engaged in treating the individual, or to persons at other facilities, including professional treatment staff of State Correctional Institutions and county prisons, when the person is being referred to that facility and a summary or portion of the record is necessary to provide for continuity of proper care and treatment.
- (2) To third party payors, both those operated and financed in whole or in part by any governmental agency and their agents or intermediaries, or those who are identified as payor or copayor for services and who require information to verify that services were actually provided. Information to be released without consent or court order under this subsection is limited to the staff names, the dates, types and costs of therapies or services, and a short description of the general purpose of each treatment session or service.
- (3) To reviewers and inspectors, including the Joint Commission on the Accreditation of Hospitals (JCAH) and Commonwealth licensure or certification, when necessary to obtain certification as an eligible provider of services.
- (4) To those participating in PSRO or Utilization Reviews.
- (5) To the administrator, under his duties under applicable statutes and regulations.

(6) To a court or mental health review officer, in the course of legal proceedings authorized by the act or this chapter.

**(7) In response to a court order, when production of the documents is ordered by a court under § 5100.35(b) (relating to release to courts).**

(8) To appropriate Departmental personnel § 5100.38 (relating to child or patient abuse).

(9) In response to an emergency medical situation when release of information is necessary to prevent serious risk of bodily harm or death. Only specific information pertinent to the relief of the emergency may be released on a nonconsensual basis.

(10) To parents or guardians and others when necessary to obtain consent to medical treatment.

(11) To attorneys assigned to represent the subject of a commitment hearing.

(b) Current patients or clients or the parents of patients under the age of 14 shall be notified of the specific conditions under which information may be released without their consent.

(c) Information made available under this section shall be limited to that information relevant and necessary to the purpose for which the information is sought. The information may not, without the patient's consent, be released to additional persons or entities, or used for additional purposes. Requests for information and the action taken should be recorded in the patient's records.

**Memorandum of Understanding  
By and Between the County of Camden (Department of Police Services) and the  
Camden Coalition of Health Care Providers**

The Camden Coalition of Healthcare Providers (CCHP) and the Camden County Police Department (CCPD) enter into this Memorandum of Understanding (“Agreement”), effective November \_\_, 2014, and commit to each other as set forth below.

**Background and Purpose**

The Camden Coalition of Healthcare Providers (CCHP) is building an integrated data system (IDS) in Camden, NJ. Linking administrative data from healthcare, criminal justice, and other social service systems, the IDS will allow for research into overlapping issues in the delivery of healthcare and criminal justice services. The goal of the project is to identify common individuals and households across each data set, understand the predictors of recidivism, hospital readmissions and other poor outcomes, and, ultimately, identify opportunities for multi-sector collaboration.

**Roles and Responsibilities**

The Camden County Police Department (CCPD) is a key participant in the IDS project. CCPD will deliver data extracts for inclusion in the IDS and make available a modest amount of time from knowledgeable staff to provide technical and program support to help understand the data elements, interpret the data analysis, and begin to develop ideas for multi-sector responses to overlapping issues identified through the data analysis.

The **Camden County Police Department** will perform the following activities:

1. Provide data regarding incidents, arrests, and such other data collected by the CCPD as agreed to by the parties (“Police data”) for Camden city for all available years since 2010. The data extracts will include individual identifiers, such as name, date of birth, and any other fields agreed upon by the parties, and will be in a mutually agreeable format.
2. Designate one or more individuals with detailed knowledge about the data sets, including field definitions and storage format, as a resource to CCHP to respond to questions.
3. Designate one or more individuals with detailed knowledge about the data collection process and operational use of the data as a resource to CCHP to respond to questions.
4. Designate an individual with the requisite knowledge and authority to serve as the Department’s designee to the Camden IDS Working Group. The IDS Working Group will be an advisory body for the IDS project and will meet bimonthly, assist in the development of research questions, review and discuss data analyses, and help identify opportunities for developing or modifying programs or interventions to improve services and address needs identified through the data.
5. Participate in the Camden IDS Working Group to complete initial data analysis and begin to develop proposed programs to address the needs of overlapping populations identified through the data.

**Camden Coalition of Healthcare Providers** will perform the following activities:

1. Receive Police Data and store it on a hospital grade server with appropriate data security measures.
2. Limit access to Police Data to those named CCHP staff or consultants involved in the IDS project, CCHP's IT systems, or who have a need to access the data, specifically for purposes of the IDS project. In the event additional
3. Indemnify the CCPD, its employees, agents and/or representatives for any breach of the agreement and defend the CCPD against any and all claims that may arise by any act or omission, directly or indirectly related to the illegal and/or unauthorized release of any privileged, confidential (HIPAA or otherwise) or any other protected information of the CCPD or any such information related to the subjects, arrestees, victims, complainants any other individuals subject to the services being provided under this agreement.
4. Clean, standardize, geocode and perform probabilistic linkage of Police Data. CCHP will provide CCPD with a copy of the cleaned, deduplicated Police Data.
5. Perform probabilistic linkage of the Police Data to health care and other data sets within the IDS at the individual record level.
6. Perform analysis of linked data including Police Data, health care data, and other social system data and share such data analysis with the Camden IDS Working Group.
7. Convene bimonthly Camden IDS Working Group and consult with it on development of research questions, interpretation of data, and development of potential multi-sector interventions.
8. Comply with data privacy and data security requirements applicable to personal health information (PHI) and such other data that are part of the IDS.
9. Shall consult with CCPD through its designee to the IDS Working Group and receive its approval prior to making public any data analysis involving Police Data.
10. Provide payments totaling \$25,000 to CCPD to cover its costs incurred in participating in the IDS project. Payments will occur at the following intervals:
  - a. \$5,000 on execution of MOU.
  - b. \$10,000 on delivery of first complete data set, including all agreed upon variables and such individual identifiers as needed to permit unique identification of individual people or incidents.
  - c. \$5,000 on substantial completion of delivery of all agreed upon Police Data.
  - d. \$5,000 following CCPD's designee having participated in two Camden IDS Working Group meetings.

**Terms and Specifications:**

The parties to this Agreement shall adhere to terms and specifications attached hereto, and same shall be incorporated herein and signed by the parties.

**Summary Statement:**

We make these commitments to one another for the purpose of developing the Camden Integrated Data System in order to better understand the relationship between health care utilization, criminal justice involvement, and other social service systems. This Agreement will be effective through November 30, 2015 unless an extension is agreed upon by both parties at an earlier date. Either party may terminate this Agreement at any time, but each party is required to give thirty (30) days written notice prior to terminating this Agreement.

Signatures of Authorized Representatives:

COUNTY OF CAMDEN  
Department of Police Services

Witness:

Ross G. Angilella,  
County Administrator

Dated:

CAMDEN COALITION OF

Witness:

Jeffrey Brenner  
Executive Director

Dated:



# CAMDEN COUNTY POLICE DEPARTMENT

**DATA SHARING TERMS AND SPECIFICATIONS OF  
LEAA Records Management System (RMS) Part I Crime Data  
LEAA Records Management System (RMS) Adult & Juvenile Arrest Data  
Computer Aided Dispatch (CAD) Calls-for-Service Data**

**Between  
Camden Coalition of Healthcare Providers (CCHP)  
and  
County of Camden, Department of Police Services**

---

The Camden Coalition of Healthcare Providers (Requestor) agrees to the following conditions in order to obtain from the Camden County Police Department (hereinafter called the CCPD) the utilization of certain criminal justice information for the purpose set forth in the Requestor's application, to be effective upon the execution of this agreement.

1. The following information shall be supplied by the CCPD. All information provided by the CCPD to the Requestor shall be subject to the conditions of this Agreement and the Memorandum of Understanding executed by and between the parties, and shall remain property of the CCPD, in the custody of the requestor. Additional information requested will be released upon the approval of Chief of Police, J. Scott Thomson.
  - Part I Crime Data for the period of Calendar Year 2010-2013 (1/1-12/31) through the duration of the integrated data system, to include the following fields:
    - Case number
    - UCR Code
    - UCR Title
    - Incident Address
    - Incident Date & Time
    - Day of Week
    - District
    - Sector
    - Grid
    - Hour Group
    - Day Reported
    - Longitude
    - Latitude
  - Adult & Juvenile Arrest Data for the period of Calendar Year 2010 - 2013 (1/1-12/31) through the duration of the integrated data system, to include the following fields:
    - Booking Number
    - Arrestee
    - Arrest Date
    - UCR Code
    - Arrest Location X
    - Arrest Location Y
    - Home Address X
    - Home Address Y

- Officer Name
  - Statute Description
  - Location of Arrest
  - Age
  - DOB
  - Sex
  - Race
  - Home Address
- Computer Aided Dispatch Data for the period of Calendar Year 2010 - 2013 (1/1-12/31) through the duration of the integrated data system, to include the following fields:
    - Event Number
    - Case Number
    - Ten Code
    - Ten Code Description
    - Priority
    - Longitude
    - Latitude
    - District
    - Sector
    - Grid
    - Disposition Code Description
    - Call Type
- Overdose Victim Data for the period of Year to Date 2014 (1/1-10/31) through the duration of the integrated data system, to include the following fields:
    - Case Number
    - Drug Type
    - Overdose Location
    - Latitude
    - Longitude
    - Date
    - Victim Name
    - Race
    - Sex
    - Age
    - Home City
    - Deceased Y/N
2. The Requestor will collect, receive, store and use all information covered by the terms of this Agreement and the Memorandum of Understanding executed by and between the parties in strict compliance with federal and state laws and regulations, and all rules, procedures and policies of CCPD that are in force and applicable during the period in which the Requestor has access to the information.
  3. The Requestor acknowledges the confidential nature of the information supplied and agrees that disclosure of individual records obtained from the CCPD to anyone not directly identified in Item 6 is totally prohibited under any circumstances. All parties receiving information of a confidential nature shall be informed of such, and shall be expected to adhere to the procedures and policies governing such information.

4. The CCPD will determine whether all copies of the information disseminated under this request will be returned or destroyed once the use described in the application has been completed.
5. Upon completion of the project referenced in the application, the Requestor shall certify in writing that all copies of the information provided under this request have been destroyed or returned as required by Item 4 above.
6. Personnel assigned by the Requestor who will have access to the information requested are: **Aaron Truchil, Dawn Wiest, Stephen Singer, and Jean Behrand**. Additional Requestor personnel may also be given access to requested information upon mutual written agreement between the parties.
7. The Requestor has assigned himself/herself as the official custodian who shall be responsible for the maintenance, care and security of all information supplied under this Agreement.
8. If the CCPD determines that the requirements of this Agreement are not satisfactorily being met, it may require the immediate return or destruction of all copies of the information obtained under this Agreement, take such actions as it deems appropriate to protect the security and privacy of this information and enforce the terms of this contract, and refuse any future requests for criminal information from the Requestor.
9. The Requestor agrees to insert in the preface of any report citing data analysis conducted pursuant to this Agreement, whether published or unpublished, the below disclaimer by CCPD of the analysis as well as the conclusions derived:

**Part I Crime Data**

**Source for Part I crime data:** *LEAA Records Management System (RMS) data. LEAA RMS Part I Crime Data is preliminary data to support operations that is subject to change based on a variety of reasons (i.e. late reporting, changes in classification etc). Any attempts to compare data to crime data classified under Uniform Crime Reporting (UCR) standards is strictly prohibited; therefore LEAA RMS Part I Crime Data should not be used for reporting purposes.*

**Adult & Juvenile Arrest Data**

**Source for arrest data:** *LEAA Records Management System (RMS) data. Adult arrest data is based on data obtained from Central Booking. One person may be booked on more than one arrest charge.*

**Computer Aided Dispatch Data**

**Source for calls-for-service data:** *LEAA Computer Aided Dispatch (CAD) calls-for-service data.*

**Overdose Data**

**Source for overdose data:** *LEAA Records Management System (RMS) data.*

10. Requestor agrees to submit any analytical reports based on the data provided under this agreement to CCPD for review and comment prior to publication or release. CCPD shall review and comment within ten (10) days of receipt of any analytical report. Kerry Yerico, or such other person identified by the CCPD, shall be the point of contact for pre-publication review requests and comments.
11. Requestor may create and share aggregate data analysis that incorporates CCPD data with CCHP staff and others involved in the Camden IDS project, provided that each individual receiving such data signs a non-disclosure agreement. Requestor shall mark any such document Confidential: Not For Distribution, until such time that the document is submitted for CCPD review in accordance with paragraph 10. The non-disclosure agreement must be substantially similar to the one attached as Exhibit A.

12. This Agreement will become effective on the date this document is signed by both parties.

IN WITNESS WHEREOF the parties hereto have caused this agreement to be executed by their duly authorized representatives:

**Camden County Police Department**

**Reauestor(s)**

By: \_\_\_\_\_  
Ross G. Angilella  
County Administrator  
County of Camden

By: \_\_\_\_\_  
Jeffrey C. Brenner  
Executive Director  
Camden Coalition of Healthcare Providers

Date: \_\_\_\_\_

Date: \_\_\_\_\_

By: \_\_\_\_\_  
Kerry Yerico  
Director  
Criminal Intelligence & Analysis

By: \_\_\_\_\_  
Aaron Truchil  
Associate Director of Research, Data and Evaluation  
Camden Coalition of Healthcare Providers

Date: \_\_\_\_\_

Date: \_\_\_\_\_

## Exhibit A: Non-Disclosure Agreement

### Non-Disclosure Agreement

This Non-Disclosure Agreement ("Agreement") is made and entered into on this \_\_\_ day of \_\_\_\_\_, 201\_ by and between THE CAMDEN COALITION OF HEALTHCARE PROVIDERS (the "Coalition"), and \_\_\_\_\_ (the "Recipient"). The Coalition and the Recipient are referred to herein each individually as "Party" and collectively as the "Parties."

Recipient is participating in work related to the Coalition's integrated data system (IDS), which combines administrative data collected by health care, law enforcement, homeless service providers, and other governmental and social service entities. As a participant in the IDS, Recipient may receive proprietary or confidential data, information, analysis, whether in tangible, or digital, electronic or other form ("Confidential Information").

Confidential Information does not include information which: (i) is independently known or already in the possession of the receiving Party at the time of disclosure as shown by the receiving Party's files and records; (ii) prior to or after the time of disclosure becomes part of the public knowledge or literature or available to the general public; or (iii) was obtained from a third party, provided that such third party is not under a confidentiality obligation to either Party to this Agreement.

NOW, THEREFORE, in consideration of any disclosure and participation in the IDS project the Coalition and the Recipient agree as follows:

1. Each Party shall: (a) hold the Confidential Information of the other Party in confidence; (b) not divulge or disclose any of the Confidential Information of the other Party or any information derived therefrom to any third person without prior written consent; (c) not make use of any of the Confidential Information of the other Party except in connection with the data analysis and investigation that is part of the IDS project and to improve the quality of services being delivered to Camden residents; and (d) not exploit, misuse, reverse engineer, or copy any of the Confidential Information of the other Party. Each Party will use at least the same standard of care in protecting against the disclosure, publication or dissemination of the other Party's Confidential Information as it uses with respect to confidential data of its own business (which in no event shall be less than a reasonable standard of care), and will so inform and direct its employees, agents and contractors receiving any such Confidential Information. Each Party will promptly notify the other Party of any unauthorized release of any of the other Party's Confidential Information.

2. Each Party shall be permitted to disclose the Confidential Information of the other Party to its employees, agents and contractors who: (a) have a need for access in connection with such Party's evaluation of the proposed contractual, business or other mutually beneficial relationship between the Parties, or such Party's obligations or performance under the current contractual, business or other mutually beneficial relationship between the Parties, as applicable; (b) have been advised of this Agreement; and (c) have signed a copy of this Agreement

3. In the event that either Party is required by legal or administrative process or by law, or by rule or regulation to disclose any of the Confidential Information of the other Party, the Party required to make such disclosure shall give prompt notice so that the other Party may seek a protective order or other appropriate relief. In the event that such protective order is not obtained, the Party required to make such disclosure shall

disclose only that portion of the Confidential Information that its counsel advises it is legally required to disclose.

4. The Parties agree to fully comply with the Health Insurance Portability and Accountability Act of 1996 and its associated regulations and, more specifically, in 45 C.F.R. §§ 160 and 164, *Standards for Privacy of Individually Identifiable Health Information, Final Rule* (the “Final Privacy Rule”), and in 45 C.F.R. §§ 160, 162 and 164, *Health Insurance Reform: Security Standards, Final Rule* (the “Final Security Rule”) collectively referred to as (“HIPAA”), as they may be applicable to the proposed or existing contractual, business and/or other mutually beneficial relationship. If appropriate, the Parties agree to execute and abide by the terms and conditions of a Business Associate Agreement in a form satisfactory to the Coalition.

5. In the event a Party is provided with access to patient medical records, the Party receiving the records agrees that all patient medical records shall be treated as confidential so as to comply with all state and federal laws and regulations regarding the confidentiality of medical records, including, but not limited to HIPAA. All medical records and materials relating to patients shall be and remain the property of the disclosing Party during the term of the Agreement and upon the termination of the Agreement.

6. Each Party understands that this Agreement does not obligate the other Party to disclose any information or negotiate or enter into any agreement or relationship. Each Party agrees that this Agreement does not grant it a license in or to (or any other right in or to) the Confidential Information of the other party.

7. Each Party shall return the Confidential Information of the other Party (and all copies, extracts and other objects or items in which such Confidential Information may be contained or embodied) upon: (a) receipt of a request by the other Party; or (b) a termination by either Party of the business relationship between the Parties, or a decision by either Party not to proceed with the proposed contractual, business or other mutually beneficial relationship, as applicable.

8. Each Party acknowledges and agrees that due to the unique nature of the Confidential Information, any breach of this Agreement would cause irreparable harm to the non-breaching party for which damages are not an adequate remedy and that such non-breaching party shall therefore be entitled to equitable relief in addition to all other remedies available at law, without the need for posting a bond or other security.

9. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of New Jersey. Any controversy or claim arising out of, or relating to, this agreement or the breach thereof shall be resolved through binding arbitration.

10. This Agreement may not be amended, supplemented, modified or extended except by written agreement signed by the Parties.

11. No failure or delay on the part of the Parties in exercising any right, power or remedy under this Agreement shall operate as a waiver of such right, power or remedy nor shall any single or partial exercise of any such right, power or remedy operate as a waiver.

12. This Agreement shall be binding on the heirs, personal representatives, employees, agents, officers, directors, successors and assigns of the parties. If any provision is found to be unenforceable, such provision will be limited or deleted to the minimum extent necessary so that the remaining terms

remain in full force and effect.

13. The term of this Agreement is 36 months from the effective date of the Agreement unless before the end of the term either Party terminates the business relationship between the Parties, or either Party decides not to proceed with the proposed contractual, business or other mutually beneficial relationship pursuant to Section 7 of this Agreement.

IN WITNESS WHEREOF the parties hereto have caused this agreement to be executed by their duly authorized representatives.

CAMDEN COALITION OF HEALTHCARE PROVIDERS

By: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

RECIPIENT

By: \_\_\_\_\_

Organization: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Agreement ID:

**Attachment 2**  
Data Transfer and Use Agreement  
Data-specific Terms and Conditions:  
Limited Data Set

**Additional Terms and Conditions:**

1. Nothing herein shall authorize the Recipient to use or further disclose the Data in a manner that would violate the requirements of Provider under 45 CFR 164.514.
2. Recipient shall not use or further disclose the Data other than as permitted by this Agreement or as otherwise required by law.
3. Recipient shall report to the Provider any use or disclosure of the Data not provided for by this Agreement within 5 business days of when it becomes aware of such use or disclosure.
4. Provider is a HIPAA Covered Entity, and the Data will be a Limited Data Set as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). In accordance with Section 164.514(e)(2) of the HIPAA Privacy Rule, the Data shall exclude the following direct identifiers of the individual or of relatives, employers, or household members of the individual:
  - (i) Names;
  - (ii) Postal address information, other than town or city, State, and zip code;
  - (iii) Telephone numbers;
  - (iv) Fax numbers;
  - (v) Electronic mail addresses;
  - (vi) Social security numbers;
  - (vii) Medical record numbers;
  - (viii) Health plan beneficiary numbers;
  - (ix) Account numbers;
  - (x) Certificate/license numbers;
  - (xi) Vehicle identifiers and serial numbers, including license plate numbers;
  - (xii) Device identifiers and serial numbers;
  - (xiii) Web Universal Resource Locators (URLs);
  - (xiv) Internet Protocol (IP) address numbers;
  - (xv) Biometric identifiers, including finger and voice prints; and
  - (xvi) Full face photographic images and any comparable images.

If the Data being provided is coded, the Provider will not release, and the Recipient will not request, the key to the code.

5. Recipient will not use the Data, either alone or in concert with any other information, to make any effort to identify or contact individuals who are or may be the sources of Data without specific written approval from Provider and appropriate Institutional Review Board approval, if required pursuant to 45 CFR 46. Should Recipient inadvertently receive identifiable information or otherwise identify a subject, Recipient shall promptly notify Provider and follow Provider's reasonable written instructions, which may include return or destruction of the identifiable information.
6. By signing this Agreement, Recipient provides assurance that relevant institutional policies and applicable federal, state, or local laws and regulations (if any) have been followed, including the completion of any IRB or ethics review or approval that may be required.
7. The parties agree to take such action as is necessary to amend this Agreement, from time to time, in order for the Provider to remain in compliance with the requirements of HIPAA.



CHARLIE CRIST  
GOVERNOR

HOLLY BENSON  
SECRETARY

**DATA SHARING AGREEMENT  
BETWEEN  
[HOSPITAL NAME]  
AND  
THE AGENCY FOR HEALTH CARE ADMINISTRATION  
FLORIDA CENTER FOR HEALTH INFORMATION AND POLICY ANALYSIS**

This agreement is entered by and between [Hospital Name] (hereinafter referred to as the Hospital) and the State of Florida, Agency for Health Care Administration, Florida Center for Health Information and Policy Analysis.

Whereas, the parties shall exchange certain data that is confidential and must be afforded special treatment and protection; and,

Whereas, data exchanged by the parties may be used or disclosed only in accordance with this agreement and state and federal law;

Now, therefore, the Hospital and the Agency agree as follows:

1. **Purpose of Agreement.** The purpose of this agreement is to govern the exchange of clinical laboratory data between the Agency and the Hospital. The Agency shall use the data specified in this agreement for a hospital quality pilot project funded through a contract with the Agency for Healthcare Research and Quality (AHRQ), AHRQ Project-07-10042. In addition, the Agency shall use the clinical data to create joined record sets by merging the clinical data with the administrative data. The Agency may share the data specified in this agreement with its subcontractors 3M HIS, for purposes of fulfilling its obligations pursuant to the AHRQ contract or any other contract to which the Hospital consents.
2. **Description of Data.** Pursuant to the terms of this agreement, the Hospital shall disclose specific clinical laboratory data elements as set forth in Attachment I to the Agency.
3. **Method of Data Transfer.** The Hospital will upload the clinical records as a comma delimited file into the Agency's secure FTP sites.



4. **Point of Contact.** The Agency designates Dr. Christopher Sullivan, AHRQ project director, whose address is 2727 Mahan Drive, Mail Stop #16 Tallahassee, FL 32308-5403, and who can be contacted at 850-414-5421, as its point of contact for this agreement.

The Hospital designates [name and title], whose address is [address], and who can be contacted at [phone number], as its point of contact for this agreement.

All correspondence regarding this agreement shall be addressed to the point of contact. The parties shall notify each other in writing within fifteen (15) days of any change of the point of contact. Notification of change of the point of contact shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

5. **Payment.** The parties shall provide the data specified in this agreement at no cost.

6. **Permissible Uses and Disclosures of Data.** Upon receipt of the data specified in this agreement, the Agency will download the records from the secure FTP sites into Oracle Database then merge them with the administrative data for a joined record set. The joined record sets will be de-identified and uploaded to a secure FTP site accessible by 3M HIS to create the APR DRG groupings and to conduct the preliminary analysis.

The Agency shall not use or further disclose, transmit, copy, or disseminate the data specified in this agreement except as permitted by this agreement or as required by federal law.

The Agency shall establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of and to prevent unauthorized use or access to the data specified in this agreement. This also governs any electronic transmission of the data.

The Agency shall not release or allow the release of the data specified in this agreement to any person or entities other than as permitted by this agreement.

The Agency shall restrict disclosure of the data specified in this agreement to the minimum number of individuals who require the information in order to perform the functions of this agreement. The Agency shall instruct individuals to whom the data is disclosed of all obligations under this agreement and shall require the individuals to maintain those obligations.

The Agency shall secure the data specified in this agreement when the data is not under the direct and immediate control of an authorized individual performing the functions of this agreement. The Agency shall make a good faith effort to identify any use or disclosure of the data not provided for by this agreement.

7. **Disclosure to Agents.** The Agency shall ensure that any agents, including, but not limited to, a contractor or subcontractor, to whom the Agency provides the data specified in this agreement agree to the same terms, conditions, and restrictions that apply to the Agency with respect to the data.
  
8. **Indemnification.** The Hospital agrees to indemnify, defend, and hold harmless the Agency from any or all claims and losses accruing to any person, organization, or other legal entity as a result of violation of this agreement to the extent permitted by federal and state law.
  
9. **Term of Agreement.** This agreement shall be effective upon execution by both parties and shall remain in effect until September 30, 2009, unless terminated by one of the parties. This agreement may be terminated by either party without cause upon thirty (30) days written notice. Notice of termination shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

The terms of this agreement may not be waived, altered, modified, or amended except by written agreement of both parties.

This agreement supersedes any and all agreements between the parties with respect to the use of the data specified in this agreement.

In witness whereof, the Hospital and the Agency have caused this agreement to be signed and delivered by their authorized representatives as of the date set forth below.

**For [Hospital]**

**For the Florida Center for Health Information and Policy Analysis**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

Christopher Sullivan  
\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

SMA II / Administrator  
\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

November 3, 2008  
\_\_\_\_\_  
Date

## Attachment I: Clinical Data Elements

Clinical Data Elements	Abbreviation	Low	High	Units
SGOT	AST	8	35	U/L
CPK MB	CKMB	0	3	ng/mL
Potassium	K	3.5	5.1	mmol/L or mEq/L
Sodium	Na	135	145	mmol/L or mEq/L
Troponin I	TnT		<0.10	ng/ml
pH	pH	7.35	7.45	
PO2.sat	PO2	80	90	mmHg
pCO2	pCO2	35	45	mmHg
Prothrombin time- International Normalized Ratio (PT-INR)	PT	11	13	seconds
Albumin	ALB	35	50	g/L
Base Excess		-3	3	
Total bilirubin fractions	Tbil	2	14	umol/L
Calcium (total)	Ca	8.6	10.1	mg/dl
Calcium (ionized)	Ical	1.15	1.29	mmol/L or mEq/L
Creatinine	CREAT	0.7	1.3	mg/dL
Glucose	GLUC	70	105	mg/dL
Alkaline phosphatase	ALP	40	130	U/L
Blood urea nitrogen	BUN	7	18	mg/dL
Hematocrit (Indices - MCV MCH)	HCT			
Hematocrit (male)	HCT	38	52	%
Hematocrit (female)	HCT	35	47	%
Mean cell Hemoglobin	MCH	26	34	pg
Mean Cell volume	MCV	80	98	fL
Platelets	Plt	150	400	x10 <sup>9</sup> /L or K/mm <sup>3</sup>
White blood cell count	WBC	4	11	x10 <sup>9</sup> /L or K/mm <sup>3</sup>
Chloride	Cl	95	108	mmol/L or mEq/L
Bicarbonate	HCO3	22	26	mEq/L
Gamma glutamyl transferase	GGT		50	U/L
SGPT	ALT	8	40	U/L
Phosphorous	PO4	1.9	4.7	mg/dL
Total Hemoglobin (male)	HGB	14	18	g/dL
Total Hemoglobin (female)	HGB	12	16	g/dL
Partial thromboplastin time	PTT	29	41	seconds
Blood/Lymph Culture-Positive				

### Additional Lab Data Elements

Date of specimen Run  
 Time of Specimen Run  
 Type of test performed  
 Reference range of test

### Demographic Data Elements

Date of birth  
 Gender  
 Ethnicity  
 Social Security Number  
 Zip Code  
 The Agency Hospital Identification Number  
 Hospital unique patient tracking number or Billing number  
 Admission Date  
 Discharge Record date  
 Discharge Record quarter

Appendix 7.7: Example Data Sharing Agreements

**AUTHORIZATION FOR MULTI-PARTY RELEASE OF HEALTH INFORMATION  
INCLUDING MENTAL HEALTH AND ALCOHOL OR DRUG TREATMENT**

The purpose of this consent is to facilitate referral(s) for treatment, case management, treatment planning, coordination of medical care and other services among providers participating in the COMMUNITY CARE MANAGEMENT NETWORK.

\_\_\_\_\_  
(Print Patient's Name)

\_\_\_\_\_  
(AKA)

\_\_\_\_\_  
(Date of Birth)

I hereby authorize \_\_\_\_\_

\_\_\_\_\_  
(Name of Requesting Agency)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Phone)

to share my health information with these agencies participating in the COMMUNITY CARE MANAGEMENT NETWORK: *(Please delete and initial any agency to which disclosure is NOT permitted.)*

Jefferson Alcohol and Drug Abuse Center  
MetroSafe

Greater Louisville Medical Society  
Louisville Metro Public Health and Wellness  
University of Louisville Hospital  
Phoenix Health Care Center  
Family and Children's Place  
Coalition for the Homeless  
Veterans Administration

Louisville Metro Department of Corrections-Inmate  
Health Services

The Healing Place  
The MORE Center  
Our Lady of Peace  
Wellspring  
Bridgehaven  
Seven Counties Services  
Louisville Metro Department of Community Services  
and Revitalization

Other: \_\_\_\_\_

\_\_\_\_\_  
(Agency Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Phone)

I give my permission for the following information to be disclosed:

*(Please delete and initial any information that is NOT to be disclosed.)*

• Initial Evaluation	• Treatment/Referral Plan	• Treatment Progress
• Laboratory Tests	• Medication History	• Discharge Summary
• Psychiatric Evaluation	• Medical/Physical History	• History/Psychosocial
• Treatment Information which may include Human Immunodeficiency Virus (HIV) Infection, Acquired Immunodeficiency Syndrome (AIDS), or Tests for HIV	• Alcohol and Other Drug Use, Abuse, and/or Treatment Information • Utilization History	• Other: _____ _____

I understand that my alcohol and/or drug treatment records may be protected by 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, and by KRS 304.17A-555. I further understand that information disclosed as a result of this authorization may no longer be protected by any applicable federal and state privacy laws, and may be disclosed by the entity or individual receiving my information.

## DATA SHARING AND USE AGREEMENT

This Data Sharing Agreement (the “Agreement”) is entered into and between \_\_\_\_\_ (the “Provider”) and the **Regents of the University of Michigan**, a Michigan constitutional corporation (the “Recipient”). This Agreement will become effective upon the date of the last signature affixed below (the “Effective Date”).

### INTRODUCTION

WHEREAS, the Provider and Recipient desire to collaborate on a project entitled: Michigan Department of Health and Human Services’ State Innovation Model (“SIM”) Patient Centered Medical Home (“PCMH”) Initiative;

WHEREAS, in performing activities of this collaboration, Provider will disclose to Recipient certain identifiable Protected Health Information;

WHEREAS Provider and Recipient wish to enter into this Data Sharing Agreement for the purpose of addressing obligations arising from the disclosure of Protected Health Information; for the following identified purpose(s):

- (1) To foster the transformation of participating PCMH primary care practices to enable interventions that impact all persons served by the Practice in a cost-effective manner using evidence-based guidelines and practices;
- (2) To support a premier model for advanced primary care in Michigan leveraging experience gained from the MiPCT demonstration;
- (3) To improve health outcomes, improve patient experience of care, and reduce preventable healthcare costs; and
- (4) To permit the sharing of payer, clinical, and demographic data with all SIM PCMH participants.

THEREFORE, in consideration of the foregoing, the parties agree as follows:

### DEFINITIONS

The following terms are defined for purposes of this Agreement. Terms used, but not otherwise defined in this Agreement shall have the same meaning as those terms in the Privacy Rule.

- a) *HIPAA* means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
- b) *Covered Entity*: Per 45 CFR 160.103 (“Definitions”), is a health plan, health care clearinghouse, or health care provider that is subject to the standards, requirements, and implementation specifications of the HIPAA Privacy Rule. Covered Entity in this Agreement shall mean the Provider.
- c) *De-identified Data*: Per 45 CFR 164.514(a), is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.
- d) *Individual*: Per 45 CFR 160.103 (“Definitions”), is the person who is the subject of protected health information and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).
- e) *Privacy Rule* shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

- f) *Protected Health Information or PHI*: Per 45 CFR 160.103 (“Definitions”), means information, maintained or transmitted in any form or medium, that: (i) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual, and (ii) identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- g) *Required by Law*: Per 45 CFR 164.103 (“Definitions”), means a mandate contained in law that compels an entity to make a use or disclosure of protected health information and that is enforceable in a court of law.
- h) *Secretary* shall mean the Secretary of the Department of Health and Human Services or his designee.

## **OBLIGATIONS OF THE RECIPIENT**

- a) To not use or disclose Provider’s Protected Health Information in any manner other than as permitted by this Agreement or as required by applicable law.
- b) To not contact or attempt to contact individuals whose data is contained in Provider’s Protected Health Information for any purpose not authorized by this Agreement.
- c) To use appropriate administrative, technical, and physical safeguards, including compliance with security provisions at 45 CFR §§ 164.308, 310, 312, and 316 pursuant to Section 3401(a) of the HITECH Act to prevent any use or disclosure of Provider’s Protected Health Information not authorized under this Agreement.
- d) To ensure that any agent, including subcontractors, to whom Recipient authorizes to use or disclose Provider’s Protected Health Information are held to the same HIPAA privacy and HITECH security standards that apply to Recipient.
- e) To report to the Provider, through its Health Systems Privacy Officer (Privacy Officer), any use or disclosure of Provider’s Protected Health Information not authorized by this Agreement that Recipient or its agents become aware of within ten (10) days of discovery.
- f) To mitigate any harmful effect caused by Recipient’s wrongful use or disclosure of Provider’s Protected Health Information in violation of this Agreement.
- g) To make available, at the Provider’s request, any internal practices, books, and recordings, including policies and procedures, relating to the use, disclosure, and security of the Protected Health Information for purposes of determining Recipient’s compliance with this Agreement and to the HIPAA privacy standards.
- h) To the extent permissible by law, to provide written notification to Provider if it receives a subpoena, court or administrative order or other discovery request or mandate pertaining to the release of any part of Provider’s Protected Health Information within five (5) days of the receipt of such a request. Written notification must occur before the Recipient responds to the request so to enable Provider time to object.

## **USES OF DATA**

- a. Recipient shall share Provider’s aggregated De-identified Data with other SIM PCMH participants for purposes including population health analysis, quality improvement, and utilization measures.
- b. Provider may also access or receive from Recipient its own raw PHI or as it has been combined with relevant payer and demographic data.

## **TERM AND TERMINATION**

- a. *Term.* The Term of this Agreement shall commence as of the Effective Date and will terminate when all of Provider's Protected Health Information is destroyed and certified as destroyed, in writing, to the Provider through its Privacy Officer.
- b. *Termination.* In the event that the Provider becomes aware of any use of Provider's Protected Health Information that is not authorized under this Agreement or required by applicable law, the Provider may (i) terminate this Agreement upon notice, (ii) disqualify (in whole or in part) the Recipient or Recipient's authorized agents from receiving Provider's Protected Health Information in the future, and (iii) report the inappropriate use or disclosure to the Secretary of the Department of Health and Human Services, as appropriate.
- c. *Effect of Termination.* Recipient will destroy all of Provider's Protected Health Information and provide written certification to the Provider through its Privacy Officer that it was destroyed, including all of Provider's Protected Health Information that is in the possession of Recipient's agents. No copies of Provider's Protected Health Information may be retained.

## **MISCELLANEOUS**

- a. *Breach or Violation.* Provider is not responsible for Recipient's violations of the HIPAA Privacy Rule unless Provider knows of a pattern of activity or practice that constitutes a material breach or violation of the HIPAA Privacy Rule. HIPAA defined violations, including those rising to the level of a breach, will be reported to the Secretary of the Department of Health and Human Services ("DHHS").
- b. *Amendment.* The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Provider to comply with the requirements of the Privacy Rule and HIPAA.
- c. *Survival.* The respective rights and obligations of Recipient shall survive the termination of this Agreement.
- d. *Interpretation.* Any ambiguity in this Agreement shall be interpreted in a manner consistent with the HIPAA Privacy Rule.
- e. *Indemnity.* Recipient shall indemnify and hold harmless Provider and its officers, trustees, employees, and agents from any and all claims, penalties, fines, costs, liabilities or damages, including but not limited to reasonable attorney fees, incurred by Provider arising from a violation of Recipient's obligations under this Agreement.
- f. *Injunctive Relief.* Recipient stipulates that its unauthorized use or disclosure of the Protected Health Information would cause irreparable harm to the Provider, and in such an event, Provider shall be entitled to institute proceedings in any court of competent jurisdiction to obtain damages and injunctive relief.
- g. *Assignment.* This Agreement may not be assigned.
- h. *Authorized Signers.* As applicable, Provider warrants and represents that it is authorized to sign this Agreement on behalf of all Practices participating with the Provider.

**IN WITNESS WHEREOF**, the parties have caused this Data Sharing Agreement to be executed by their respective duly authorized representatives effective as of the day and year set forth below.

**REGENTS OF THE UNIVERSITY  
OF MICHIGAN**

By: \_\_\_\_\_  
(Signature)

Name: \_\_\_\_\_  
(Please Print)

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**PROVIDER**

By: \_\_\_\_\_  
(Signature)

Name: \_\_\_\_\_  
(Please Print)

Title: \_\_\_\_\_

Date: \_\_\_\_\_

# User Policy, Responsibility Statement & Code of Ethics

---

*For Lake County's ServicePoint®*

## User Policy

Partner Agencies shall share information for the purposes of coordinating services to individuals enrolled in ServicePoint®. Aggregate non-identifying data may also be used for reporting unduplicated counts to state, federal and other funding sources. Lake County seeks to establish a uniform, consistent, and accurate source of data for all member participants and stakeholders.

It is a Client's decision about which information, if any, entered into the ServicePoint® system shall be shared and with which Partner Agencies. The *Consent To Use ServicePoint®* must be signed if the Client agrees to share basic information with Partner Agencies. A separate *Release of Information* form must be signed if the Client agrees to share anything other than basic identifying information.

**The ServicePoint® system is a tool to assist agencies in focusing services and locating alternative resources to help clients. Therefore, agency staff should use the Client information in the ServicePoint® system to target services to the Clients' needs.**

To the greatest extent possible, data necessary for the development of aggregate reports of homeless services, including services needed, services provided, referrals and client goals and outcomes should be entered into the system in a timely and accurate manner.

## Users Code of Ethics

- A. The ServicePoint User has primary responsibility for his/her Client(s).
- B. Each ServicePoint User should maintain high standards of professional conduct in the capacity as a ServicePoint User.
- C. ServicePoint Users must treat Partner Agencies with respect, fairness and good faith.
- D. ServicePoint Users have the responsibility to relate to the Clients of other Partner Agencies with full professional consideration.

## Strong Password Protocols

Minimum length of eight characters which:

- Are not based on anything somebody else could easily guess or obtain using person related information, e.g. names, telephone numbers, dates of birth, etc.
- Are free of consecutive identical characters or all-numeric or all-alphabetical groups
- Are free of word or number patterns
- Are not names or words in any dictionary including English, foreign languages, and technical dictionaries (legal, medical, etc.)
- Contains at least one uppercase letter, one lowercase letter, and 2 numbers

## User Responsibility

Your User ID and Password give you access to the Lake County ServicePoint® system. **Initial each item below to indicate your understanding and acceptance of the proper use of your User ID and password.**

Failure to uphold the confidentiality standards set forth below is grounds for immediate termination from the ServicePoint® system.

- My User ID and Password are for my use only and must not be shared with anyone.
- I must take all reasonable means to keep my password physically secure.
- I understand that the only individuals who can view information in the ServicePoint system are authorized users and the Clients to whom the information pertains.
- I may only view, obtain, disclose, or use the database information that is necessary to perform my job.
- I am required to understand and obey all requirements indicated in the *Service Point® Business Agreement* and *Notice of Privacy Practices*.
- Each client must be informed of their privacy rights and sign the *Consent to Use ServicePoint®* before their information is entered in to the database.
- Client information will only be shared in a manner consistent with the signed consents and releases of information by the client.
- If I am logged Into ServicePoint® and must leave the work area where the computer is located, I **must log-off** of ServicePoint® before leaving the work area.
- A computer that has ServicePoint® open and running shall never be left unattended.
- Failure to log off ServicePoint® appropriately may result in a breach in client confidentiality and system security.
- Hard copies of ServicePoint® information must be kept in a secure file.
- When hard copies of ServicePoint® information are no longer needed, they must be properly destroyed to maintain confidentiality.
- If I notice or suspect a security breach, I must immediately notify the Agency Administrator for ServicePoint® or the Lake County System Administrator at 847-377-2331.

**I understand and agree to comply with all the statements listed above.**

\_\_\_\_\_  
ServicePoint User – **Print Name & Sign**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency Administrator – **Print Name & Sign**

\_\_\_\_\_  
Date

*Note: Forms should be signed by the User & Agency Administrator, a copy kept on site and a copy delivered to the Lake County ServicePoint Administrator.*

## Appendix 7.8: Barriers to Data Sharing

### Barriers

Below are the descriptions for the barrier titles listed in the Barriers section of the Current State Sharing assessment.

Barrier Title	Description
Internal Bureaucracy & Red Tape	The difficulty in acquiring the necessary permissions to share data and creating the necessary awareness of the need to share information.
Legal regulations to storing new data	Acquiring approval from risk and compliance teams to store new types of data and the review process for the associated collection practices can be time consuming and require significant effort depending on the new information to be collected.
Nowhere to store behavioral health information in existing technology programs	Fields do not exist within current programs to store select data and would need to be built.
Legal Regulations to begin sharing data	Acquiring approval from internal risk and compliance teams to share stored aggregated and personal identifiable information can be time consuming and requires significant effort.
Constant changes to policies and regulations	Internal and governmental changes to policies and regulations demand operational resources. Organizations relayed feelings of constantly devoting resources to adapt to new practices which prevented them from pursuing other opportunities.
Varying interpretations of the law	The implementation of a law or policy can differ across organizations. To share data, organizations would need to invest time and resources to come to an agreement on how to operationalize policies for the data sharing program to be compliant.
Navigating consent forms and determining validity across organizations	740 ILCS 110 requires that a consent to release information be signed to share data. To share data, organizations will need to establish and agree to governing rules that outline allowed sharing, such as protocols for when a consent form is signed at two different locations but with conflicting information and who has the authority to update stored information on behalf of consent forms.
Privacy and Security System Compliance	The need to ensure that existing programs or changes to the programs meet the required privacy and security standards, verifying that, if a central repository is selected, the supporting new technology is compliant, and that data sharing mediums are secure.
Security Breach & Leaked information	Organizations' fear of hackers, stolen information, ransom attempts, and the associated ownership, liability, and responsibility.

## Appendix 7.8: Barriers to Data Sharing

Cost of technology system/automation required to participate	Funding for the technology to support a data sharing model, if needed, will pose a barrier as some products are very costly and there are alternative uses for those funds.
Standardization of encryption requirements across participants	When data is shared electronically, the degree to which each element of the message is encrypted needs to be agreed upon by contributing parties.
Report Generation	Organizations cited report generation as a large barrier to sharing patient and organization level data. Either the program organizations use does not aggregated data easily or the metadata required to support a report is not easily accessible. The reports that are generated require some manual work which can threaten data quality, and customizing existing reports is very difficult.
Need to train on new practices for documenting new data	If new policies and practices are put into place, organizations will need time to train their employees to adopt new practices with high accuracy.
Unclear of role in sharing data	Some organizations had difficulty envisioning how their data could contribute to a behavioral health data sharing program and how they could benefit from data sharing.
Data governance (ownership, responsibilities, and maintenance)	A barrier to participating for some organizations is the fear of who will own the data, the work required to standardize the data across organizations, and not knowing how the data sharing framework will be established and maintained.
FTE needs	Many organizations voiced concerns over the employee needs required to support the initiation of a program as well as sustaining the program moving forward.
Constant Change makes organizations leery of committing	With an increased eye on behavioral health nationwide, the industry is positioned to continue a high volume of changes which can make organizations hesitate to commit resources.
Competition for business and funding	Exposing the services an individual receives increases competition amongst service providers which can negatively impact revenues and funding.
Coming to agreement on the standardization of data	Data standardization will require the contributing parties to agree on the format, data collection, and storage of each data point that is shared to help improve data accuracy. Changes to current processes may require changes to their current programs.
Education and required technology skillsets to operate in a data sharing agreement	Operators and providers that are less familiar with data sharing agreements will need additional education to understand and operate efficiently within a more advanced technological environment.

# What current initiatives are underway that we should know about that will directly or indirectly support/enhance access and delivery of behavioral health services to individuals and families?

Current run (last updated Jun 16, 2017 3:30pm)

16

Participants

1

Polls

25

Average responses



Average engagement

## Survey

1. What current initiatives are underway that we should know about that will directly or indirectly support/enhance access and delivery of behavioral health services to individuals and families?

## Responses

Participant	Question	Response
Unregistered	1	Fuse initiatives
Unregistered	1	100,000 Homes, Built for Zero
Unregistered	1	Jail Data Link
Unregistered	1	Rule 132 service definition changes
Unregistered	1	Expand rule 132 to allow substance treatment to better cover long Term case management
Unregistered	1	BHTCC
Unregistered	1	LCHD Live Well LC behavioral health action plan
Unregistered	1	Mental health collaborative
Unregistered	1	None known (sent with Balloons)
Unregistered	1	Mental Health First Aid trainings
Unregistered	1	Lake County Opioid Initiative
Unregistered	1	Service point; LCHD studies,

<b>Unregistered</b>	<b>1</b>	Any school efforts?
<b>Unregistered</b>	<b>1</b>	Live Well Lake County Behavioral Health Action Team
<b>Unregistered</b>	<b>1</b>	Coordinated entry into PSH for chronically homeless based in ServicePoint; referral network and potential data sharing in ServicePoint
<b>Unregistered</b>	<b>1</b>	Coordinated entry into PSH for chronically homeless based in ServicePoint; referral network and potential data sharing in ServicePoint
<b>Unregistered</b>	<b>1</b>	Alliance for human services. Partnership for a safer lake county. Lake county behavioral health community action plan
<b>Unregistered</b>	<b>1</b>	Round Lake Area School Health and Wellness Center
<b>Unregistered</b>	<b>1</b>	The research for the last 2 years by Lake County United regarding crisis center , CIT training, and supportive housing.
<b>Unregistered</b>	<b>1</b>	BHTCC; TIM courts
<b>Unregistered</b>	<b>1</b>	Behavioral Health Action Team, Suicide Task Force
<b>Unregistered</b>	<b>1</b>	Sustain
<b>Unregistered</b>	<b>1</b>	BH Action Team
<b>Unregistered</b>	<b>1</b>	Opioid Task Force
<b>Unregistered</b>	<b>1</b>	1115 waiver

# What communities nationally are you aware of that have been successful in cross system collaboration in addressing the needs of individuals and families?

Current run (last updated Jun 16, 2017 3:31pm)

13

Participants

1

Polls

16

Average responses



Average engagement

## Survey

1. What communities nationally are you aware of that have been successful in cross system collaboration in addressing the needs of individuals and families?

## Responses

Participant	Question	Response
Unregistered	1	Houston Texas
Unregistered	1	Columbus Ohio
Unregistered	1	100,000 Homes Campaign
Unregistered	1	San Antonio, TX; King County, WA; Miami-dade
Unregistered	1	Camden. San Antonio. Miami Dade. But need to be mindful of geographic and other differences.
Unregistered	1	San Diego and Seattle King County and Portland
Unregistered	1	?
Unregistered	1	Camden, NJ; Dade County FL; San Antonio, TX;
Unregistered	1	Johnson county ,KS
Unregistered	1	Oakland, CA - only because of funding support...
Unregistered	1	Denver FUSE and pay for success bonds jointly issued by city and county for PSH
Unregistered	1	Akron, Ohio
Unregistered	1	DuPage County Illinois

<b>Unregistered</b>	1	NY is doing a good job of looking at housing as a right and has programs that solve housing and homelessness problems
<b>Unregistered</b>	1	Not sure
<b>Unregistered</b>	1	New York City

# Concept /Principle from draft Charter, "Outcomes are standardized and measured at the individual, provider and service system level." What outcome or process measures would you like to see?

Current run (last updated Jun 16, 2017 3:30pm)

19

Participants

1

Polls

25

Average responses



Average engagement

## Survey

1. Concept /Principle from draft Charter, "Outcomes are standardized and measured at the individual, provider and service system level." What outcome or process measures would you like to see?

## Responses

Participant	Question	Response
Unregistered	1	Private sector funding support
Unregistered	1	Permanent Affordable Housing and Employment
Unregistered	1	Psychiatrist coordination of info inside and outside jail
Unregistered	1	Reduced use of emergency health and criminal justice services
Unregistered	1	Number of people utilizing/accessing behavioral health services on a regular basis with a correlating decline in #of people in the jails/reduction in avg days
Unregistered	1	stay
Unregistered	1	None
Unregistered	1	Employment duration of those with acute/severe MH issues
Unregistered	1	Improved care coordination
Unregistered	1	Need more data sharing
Unregistered	1	Service utilization would rise
Unregistered	1	Less contact with the criminal justice system by individuals with mental illness

Unregistered	1	Shorter delay in access to services
Unregistered	1	Sufficient funding for mental health providers.
Unregistered	1	Level of Access to MH services
Unregistered	1	Satisfaction with current services
Unregistered	1	Not aware of any
Unregistered	1	Increase number of CIT trained officers
Unregistered	1	Akron, Ohio
Unregistered	1	Patients not having a 6 month wait to get help
Unregistered	1	Housing stability Medication needs met Reduced days in jail
Unregistered	1	Cultural context
Unregistered	1	Increase in jail diversion; decrease in length of time to see a psychiatrist; increase in affordable housing
Unregistered	1	Care coordination and
Unregistered	1	Reduced Suicide

# Concept / Principal from your draft Charter - "Services are person centered, strengths based and trauma informed." Poll Question - Does the Lake County community have a shared understanding and application of these concepts across system partner organizat

Current run (last updated Jun 16, 2017 3:27pm)

9

Participants

1

9

Average responses



Average engagement

## Survey

1. Concept / Principal from Question - Does the Lake County community have a shared understanding and application of these concepts across system partner organizations?

The engagement score shows how many audience members responded to the reported polls, on average.

If you've entered the total audience size, it's calculated by dividing the number of unique participants by the number of audience members.

If no audience size is entered, we'll divide by the total participants across all reported polls.

Concept / Principal from Question - Does the Lake County community have a shared understanding and application of these concepts across system partner organizations?"

## Responses

Participant	Question	Response
Unregistered	1	B - Somewhat
Unregistered	1	C - No
Unregistered	1	B - Somewhat
Unregistered	1	A - Yes
Unregistered	1	C - No
Unregistered	1	C - No
Unregistered	1	B - Somewhat
Unregistered	1	B - Somewhat
Unregistered	1	B - Somewhat

# What are the system collaboration strengths of Lake County that should be leveraged in this data sharing project?

Current run (last updated Jun 16, 2017 3:28pm)

18

Participants

1

Polls

25

Average responses



Average engagement

## Survey

1. What are the system collaboration strengths of Lake County that should be leveraged in this data sharing project?

## Responses

Participant	Question	Response
Unregistered	1	2 FQHCs
Unregistered	1	Sheriff can provide leadership In County coordination of mental health coordination
Unregistered	1	Lake County Development has pivoted to strengthen housing
Unregistered	1	Cooperative spirit at times
Unregistered	1	The recognition that the need is real, so there is a strong desire to collaborate.
Unregistered	1	We are in this room
Unregistered	1	Cubs
Unregistered	1	Providers talk to each other's about needs of families
Unregistered	1	County leadership
Unregistered	1	Strong executive leadership
Unregistered	1	We communicate with each other and all agree that this is a significant issue.
Unregistered	1	Many, many, providers, non profits, community org.
Unregistered	1	Cubs
Unregistered	1	Growing desire to coordinate strategically across Lake County.

- Unregistered**                    1    Hospital beds although not enough
  
- Unregistered**                    1    LC Behavioral Health action team
  
- Unregistered**                    1    Existing partnerships and initiatives
  
- Unregistered**                    1    Sox
  
- Unregistered**                    1    Willingness to help and be open to new ideas
  
- Unregistered**                    1    Recognizing the need to take action on this issue by so many partners and organizations
  
- Unregistered**                    1    Caring government and community partners who want to help
  
- Unregistered**                    1    Service Point, Alliance for Human Services, Sustain
  
- Unregistered**                    1    Excellent programs, no real turf battles
  
- Unregistered**                    1    Strong providers and nonprofits
  
- Unregistered**                    1    Cubs

Appendix 7.10: Data Matrix – Extended List of Data / Measures

Data Matrix

This Data Matrix is intended to highlight how data measurements can be reached with existing or new data points and/or agreements and protocols. The purpose of providing this matrix is to brainstorm data that can be used to support key decisions. To support on-going decision making, programs and continuous data sharing on a set frequency would need to be established. This list does not include all of the data measurements or points that *could be* shared nor is this matrix a list of all the data points that *will be* shared.

Furthermore, this list does not suggest that it is possible or easy to share select data points, it is simply a tool to surface and raise awareness of the data that would be most impactful for decision making.

The data below is what has been collected or brainstormed to date and is subject to change.

<b>Key Decision Legend:</b>	<b>2 - Are the service needs of those accessing behavioral care being met?</b>	<b>3 - Are the services provided impacting outcomes and making a difference for individuals and families served?</b>
<b>1 - Who is in need of or seeking behavioral health care and what are their overall service needs?</b>		

Key Decisions	Sector (s)	Service Provider Type within Sector	Data Measurement	Calculation (if needed)	Data Point	Available	Standard-ized	Comments and Potential Barrier to overcome
1	Healthcare	BH Provider	individuals are receiving BH services (over the past month)	Total of behavioral health record with an initial service date but no close date (pulled the first or last data of the month)	Initial service date Close service date or Count service visits/encounters using claims data	N	N	BH Provider subgroup to agree on measure standardization Depending on the data sharing model selected, this could be capture through reports sent in by Providers or could be capture through a central repository
1	Healthcare	BH Provider	NEW individuals/families are accessing BH services (over the past month)?	Total of behavioral health record with an initial service date that falls within the last month	Initial service date or New patients using claims data	N	N	BH Provider subgroup to agree on measure standardization Depending on the data sharing model selected, this could be capture through reports sent in by BH Providers or could be capture through a central repository
1	Healthcare	BH Provider	Behavioral health conditions	# of individuals with dx	Diagnosis	Y	Y	
1	Healthcare	BH Provider	Functioning level	# of individual per functioning level	Functioning scores	Y	N	BH group to explore and make decisions about what standardized functioning scores to use (e.g.. Consider functioning scores that are required by state for submission upon entry and exit of services)
1	Healthcare	BH Provider	HEDIS measures	Multiple	Multiple	Y	Y	Explore what requirements that the new MCOs may have around collecting this data
1	Healthcare	Risk and health assessment scores	Risk measures	Multiple	Multiple	Y	N	BH group to explore and make decisions about what standardized risk scores to use (e.g.. Consider functioning scores that are required by state for submission upon entry and exit of services)
1	Healthcare	Risk and health assessment scores	Protective Factor measures	Multiple	Multiple	Y	N	BH group to explore and make decisions about what standardized protective factor scores to use (e.g. Consider functioning scores that are required by state for submission upon entry and exit of services)
1	Healthcare	BH Provider	Overall service intensity needs of individuals seeking services	# with HIGH need score / # in service # with MEDIUM need score / # in service # with LOW need score / # in service	Service Level Stratification Score	N	N	BH group to explore and make decisions about a standardized risk stratification criteria could be used.
1	Healthcare	BH Provider	overall service intensity needs of individuals seeking services <i>by specialty populations</i>	# with HIGH need score / # in service in special population # with MEDIUM need score / # in service in special population # with LOW need score / # in service in special population	Specialty population data element Service level score	N	N	BH group to explore and make decisions about what standardized risk stratification criteria could be used. Specialty populations to capture are (e.g. justice involved, child welfare involved, adults/children, SMI, SED, etc.)
1	Healthcare	BH Provider	level of care to which individuals are accessing care	Total of claims by service location	Claims data by service location / service code	Y	Y	This is a data measurement that could be negotiated with the managed care companies or with the Medicaid agency for that population. Alternatively, if hospitals provided the claims data with similar formats, the information could be loaded and analyzed with a tools.
2	Healthcare	BH Provider	Timeliness of routine services - for an Assessment	Average length of time for an appointment % that are within 7 days	Date of service request Date of appointment Date of service request Date of appointment	Some providers	N	BH Provider subgroup to agree on measure standardization
2	Healthcare	BH Provider	Timeliness of routine services - for a medication assessment	Average length of time for an appointment % that are within 7 days	Date of service request Date of appointment Date of service request Date of appointment	Some providers	N	BH Provider subgroup to agree on measure standardization
2	Healthcare	BH Provider	Timeliness of routine services - for access to on-	Average length of time for an appointment	Date of service request Date of appointment	Y	Y	If not available in user-facing programs, available as time stamp data within the scheduling software.

			going treatment services			Y	Y	
2	Healthcare	BH Provider	Timeliness of routine services - for support services (e.g. living skills)	Average length of time for an appointment	Date of service request Date of appointment	Y	Y	If not available in user-facing programs, available as time stamp data within the scheduling software.
2	Healthcare	BH Provider	Timeliness of routine services - for accessing peer / family support services	Average length of time for an appointment	Date of service request Date of appointment	Y	Y	If not available in user-facing programs, available as time stamp data within the scheduling software.
2	Healthcare	Service length of time	Average length of service duration for routine services	Total of (Date of entering services - current date in days) / # of individuals actively receiving services	Date of entering services	Y	Y	If not available in user-facing programs, available as time stamp data within the scheduling software.
					# of individuals actively receiving services	N	N	Providers to determine the definition of 'actively seeing' as the length of time inactive or archiving standards across hospitals and provider can differ.
2	Healthcare	BH Provider	Timeliness of Follow-up care appointment - for an emergent service	Average length of time for an appointment	Date of discharge from emergent service	Some	N	BH group to agree on standardization. Many forward facing programs will include the data of discharge, but if transfers for continuing services, then this population may need to be removed from this calculation. This may require the presence of other data points by which to filter
					Date of follow-up care	Y	Y	
2	Healthcare	BH Provider	Timeliness of Follow-up care appointment - for a urgent service	Average length of time for an appointment	Date of discharge from urgent service	Y	Y	BH group to agree on standardization. Many forward facing programs will include the data of discharge, but if transfers for continuing services, then this population may need to be removed from this calculation. This may require the presence of other data points by which to filter
					Date of appointment	Y	Y	
1	Healthcare	BH Provider	Service Capacity - Routine Services - # psychiatrists/NP, PA per 100,000 lives	# psychiatrists/NP, PA per 100,000 lives	# psychiatrists/NP, PA # of MEB lives	Y	Y	an use a proxy such as an estimation based on national best practices May need to confirm definition across organizations relative to the services provided to have a standardized criteria for the population
2	Healthcare	Care Management	# / % of individuals are assigned to a care management program for those with medium to high levels of care needs	count of high and medium need individuals assigned to a care coordinator	Patients with High needs Patients with Medium Needs Care Coordinator contact flag within each system	N	N	BH provider to determine standards for high and medium need. Additionally the BH group needs to identify current definition and services provided by care coordinators across organizations. The presence of a care coordinator can be documented in a variety of ways across programs and there needs to be a protocols for combining that information.
2	Healthcare	Care Management	# of new individuals be assigned to care management program	count of new individuals into care coordinator program	Total number of individuals assigned to care coordinators at two different times	N	N	BH group to determine the frequency with which to evaluate this data. Dependent on a high quality consolidation of care coordinator information across organizations
2	Healthcare	Care Management	# of individuals removed from care management program (by reducing service needs or for lack of contact after outreach)	differential in individuals for a care coordinator program	Total number of individuals assigned to care coordinators at two different times	N	N	BH group to determine the frequency with which to evaluate this data. Dependent on a high quality consolidation of care coordinator information across organizations
2	Healthcare	Care Management	For those assigned to care management - # with justice involvement	Overlap btw care coordinator program and justice involvement	Justice Involvement Care Coordinator	N	N	BH provider to define the factors that signify justice involvement (i.e. court filing, police encounter). Requires PII be exchanged to match names across justice and care coordination systems.
2	Healthcare	Care Management	For those assigned to care management - # with other special population characteristics	Overlap between individuals in a care coordinator program and a specialty population	Specialty program Care Coordinator	N	N	Need data points within programs that an individual is a part of a specialty population.
2	Healthcare	BH Provider	Service Capacity - Routine Services- # of BH Professional providers per 100,000 (e.g. licensed SW, Counselor, MH therapist, SA	Professional availability : covered lives	# of BH Professional providers # of MEB lives	N	N	BH group to define the list to include in professional lives
						N	N	BH group to define how to identify these individuals across programs or to use proxies based on population data
2	Healthcare	BH Provider	Service Capacity - Routine Services - # of certified peer support specialists per 10,000 lives	Peer support : covered lives	# of certified peer support specialists	Y	N	This information is likely known within each organization, but definitions should be compared across the community to arrive at a system level calculation and ensure high data quality
					# of MEB lives	Y	N	This information may be defined within each organization but it needs to be defined across the community as well.
2	Healthcare	BH Provider	Service Capacity - Routine Services- # of certified family support specialists per 10,000 lives	family support : covered lives	# of certified family support specialists	Y	N	This information is likely known within each organization, but definitions should be compared across the community to arrive at a system level calculation and ensure high data quality
					# of MEB lives	Y	N	This information may be defined within each organization but it needs to be defined across the community as well.

3	Healthcare	BH Provider	Outcomes for those who have accessed services - improved stable housing	differential in outcome calculation over a period of time	outcome measures presence of stable housing	N	N	BH Group to develop specific outcome measures leveraging what is already required by the state for submitting housing information.
3	Healthcare	BH Provider	Outcomes for those who have accessed services - improved relationships	differential in outcome calculation over a period of time	outcome measures improved relationships	N	N	BH Group to develop specific outcomes measures and leveraging data collected on intake forms and through counseling notes related to family and personal networks.
3	Healthcare	BH Provider	Outcomes for those who have accessed services - meaningful daily activity (work, school, volunteer)	differential in outcome calculation over a period of time	outcome measures presence of meaningful daily activity	N	N	BH Group to develop specific outcomes measures and leveraging data required by the state for employment and school purposes.
3	Healthcare	BH Provider	Outcomes for those who have accessed services - effectively managing their mental health	differential in outcome calculation over a period of time	outcome measures ranking of ability to manage mental health	N	N	BH Group to develop specific outcomes measures and leveraging data the documents, ranks or score one's ability to manage their own health.
3	Healthcare	BH Provider	Outcomes for those who have accessed services - effectively managing substance abuse	differential in outcome calculation over a period of time	outcome measures ranking of ability to manage substance abuse	N	N	BH Group to develop specific outcomes measures and leveraging data the documents, ranks or score one's ability to manage their substance abuse.
3	Healthcare	BH Provider	Outcomes for those who have accessed services - avoiding justice involvement	differential in outcome calculation over a period of time	outcome measures change in the frequency of justice involvement or lack of data within the justice system	N	N	BH Group to develop specific measure leveraging information already collected by justice to identify the presence and frequency of using justice services.
3	Healthcare	BH Provider	Outcomes for those who have accessed services - ability to manage any physical health conditions improved	differential in outcome calculation over a period of time	outcome measures presence of physical health needs score on a ability to address physical health needs	N	N	BH Group to develop specific measure leveraging information already collected by the healthcare system to identify needs and assess competency in individuals caring for their needs
3	Healthcare	BH Provider or MCO	individuals / families satisfaction with their services	# with a positive response / total # surveyed	Satisfaction survey result	U	U	Would need to develop a Satisfaction Survey Explore working with MCOs who may have to do this for a geographic region
3	Healthcare	BH Provider or MCO	service system address the behavioral health service needs of those served	# with a positive response / total # surveyed	Satisfaction survey result	U	U	Would need to develop a Satisfaction Survey Explore working with MCOs who may have to do this for a geographic region
3	Healthcare	BH Provider or MCO	service system address or connect them with other social services needed	# with a positive response / total # surveyed	Satisfaction survey result	U	U	Would need to develop a Satisfaction Survey Explore working with MCOs who may have to do this for a geographic region
3	Healthcare	BH Provider or MCO	services delivered in a setting that addressed their needs	# with a positive response / total # surveyed	Satisfaction survey result	U	U	Would need to develop a Satisfaction Survey Explore working with MCOs who may have to do this for a geographic region
3	Healthcare	BH Provider or MCO	service providers respect of cultural needs	# with a positive response / total # surveyed	Satisfaction survey result	U	U	Would need to develop a Satisfaction Survey Explore working with MCOs who may have to do this for a geographic region
3	Healthcare	Supportive Employment Service Provider	Amount of Supportive Employment Services provided	Total # of individuals with a claim for Supportive Employment	Claims data with supportive employment code	U	Y	Claims data - Employment Service Provider representatives to assist with defining how to extract this information from standard filings
3	Healthcare	Supportive Employment Service Provider	Service Capacity - Employment Support - # capacity/availability for employment supportive services	# of supportive employment services slots available	Supportive Employment roles available	Y	Y	Claims data - Employment Service Provider representatives to assist with defining how to extract this information employer intake and need forms.
2	Healthcare	Warmline service provider	Timeliness to answer Warmline calls (peer to peer support line)	Average speed of answer	Time to answer call from ring time	N	N	Need a well known warmline phone number and a program to measure incoming call and response time
2	Healthcare	Warmline service provider	Warmline Abandonment Rate	# Calls dropped before an answer (calls not answered) / Total # Calls	Calls dropped before an answer (calls not answered) Total # Calls	N	N	Need a well known warmline phone number and a program to measure incoming call and response time
2	Healthcare	Nurse support line provider	Timeliness to answer Nurse Support calls	Average speed of answer	Answer speed	N	N	Need a well known nurse support phone number and a program to measure incoming call and response time
2	Healthcare	Nurse support line provider	Warmline Abandonment Rate	# Calls not answered / Total # Calls	Calls Not Answered Total # Calls	N	N	Need a well known nurse support phone number and a program to measure incoming call and response time
1,2	Healthcare	Crisis Call Center	Volume (Daily, monthly)	Total call volume for a month / # days in month	Call volume	Y	U	No universal number for a crisis center across the county
1,2	Healthcare	Crisis Call Center	Average Answer Time	Average speed of answer	Answer speed	N	N	program to measure call statistics including; incoming call time, time to answer, call duration, abandonment rates etc.

1,2	Healthcare	Crisis Call Center	Abandonment Rate	# Calls not answered / Total # Calls	Calls Not Answered Total # Calls	N	Y	program to measure call statistics including; incoming call time, time to answer, call duration, abandonment rates etc.
1,2	Healthcare	Crisis Call Center	Average Talk Time	Total talk time / # calls	Talk time Total # of calls	N	Y	program to measure call statistics including; caller source, incoming call time, time to answer, call duration, abandonment rates etc.
1,2	Healthcare	Crisis Call Center	Crisis Calls transferred from <b>911</b> are answered within X seconds	Average speed of answer	Average speed of answer	N	N	program to measure call statistics including; caller source, incoming call time, time to answer, call duration, abandonment rates etc. Would require establishing a telephone # specific for 911
1,2	Healthcare	Crisis Call Center	Average Answer Time to respond to calls from <b>Police officers</b>	Average speed of answer	Answer speed answer for telephone line provided for emergency services	N	N	program to measure call statistics including; caller source, incoming call time, time to answer, call duration, abandonment rates etc. Would require establishing a telephone # specific for use by police
1,2	Healthcare	Crisis Call Center	Mobile Teams sent in response to requests from <b>law enforcement</b> to support individual/family in need of BH intervention	Total # of MTs dispatched to law enforcement	Law enforcement request for BH Intervention Mobile team dispatch	N	N	Would require development of capability of crisis line to accept calls and dispatch mobile teams program to document the result of calls- such as mobile team dispatched
1,2	Healthcare	Crisis Call Center	Calls from <b>Emergency Departments</b> answered within X seconds	Average length of time to answer calls	Time to answer call from ring time	N	N	Requires development Common performance measure for any call center Would require establishing a telephone # specific for use by Ends
1,2	Healthcare	Crisis Call Center	Mobile Teams sent to <b>Emergency Department</b> to assist in discharge from ED.	Total # of MTs dispatched to ED	Emergency Department request for assistance with discharge Mobile team dispatch	N	N	Would require development of capability of crisis line to accept calls and dispatch mobile teams
1,2	Healthcare	Crisis Call Center	Recidivism - repeat service within 30/60/90 days	# of individuals with repeat calls within 30/60/90 days	% of individuals with repeat calls to the crisis line	N	N	program to measure call statistics including; caller source, incoming call time, time to answer, call duration, abandonment rates etc.
1,2	Healthcare	Mobile Teams	Mobile Teams average response time to individuals/families in the community	Total of mobile team response times / total # of mobile teams	Mobile Dispatch Dispatch Time Arrival	N	N	Requires development
1,2	Healthcare	Mobile Teams	Mobile Teams average response time to <b>law enforcement</b> request for assistance in the community	Total of mobile team response times sent to law enforcement / total # of mobile teams sent to law enforcement	Mobile Dispatch to law enforcement Dispatch Time Arrival	N	N	Requires development
1,2	Healthcare	Mobile Teams	Mobile Teams average response time to individuals in an <b>Emergency Department</b>	Total of mobile team response times sent to emergency departments / total # of mobile teams sent to emergency departments	Mobile Dispatch to ED Dispatch Time Arrival	N	N	Requires development
1,2	Healthcare	Mobile Team	Average on-scene time	Total of arrival time - off scene time / #	Arrival time Off scene time	N	N	Requires development
1,2	Healthcare	Mobile Team	Mobile Team purpose	Number of incidents per issue type	standard list of crisis types	N	N	Could pull from other communities to define
1,2	Healthcare	Mobile Team	Disposition	count of incidents across dispositions	Disposition type	N	N	Could define for Lake County or leverage what other communities have done to categorize dispositions
1,2	Healthcare	Mobile Team	# / % with high utilization	Total individuals with multiple dispatches	Dispatches to the same person	N	N	BH Group to develop
1,2	Healthcare	Mobile Team	Service Capacity - Behavioral health mobile team capacity (# of teams per day)	Total of # mobile teams per day	# of mobile teams	N	N	Requires development
1,2	Healthcare	Crisis Walk-in	Volume (Daily, monthly)	Total # of admissions	Admissions	N	N	
1,2	Healthcare	Crisis Walk-in	Average wait time (Daily, monthly)	Time of entry to time of service to individual	Arrival Time Time for BH staff to service individual	N	N	
1,2	Healthcare	Crisis Walk-in	Volume for <b>police</b> drop offs (Daily, monthly)	Total # of admissions	admissions Referral source identified as police	N	N	
1,2	Healthcare	Crisis Walk-in	Average time <b>police</b> have to wait when dropping off an individual	Total time of police waiting / total # of admissions by police referrals	Arrival Time Time for BH staff to service individual Referral source	N	N	Need to develop capacity
1,2	Healthcare	Crisis Walk-in	average length of stay	Total of Arrival time - discharge time / # individuals served	Arrival Time Discharge Time	N	N	Need to develop capacity

1,2	Healthcare	Crisis Walk-in	Reason for service (depression, suicidal thoughts, anxiety, relational etc.)	# of individuals by reason code	Reason for services	Y	U	Need to develop capacity
1,2	Healthcare	Crisis Walk-in	Acuity	# of individuals by acuity score	Acuity Score	N	N	Could pull from other communities to define
1,2	Healthcare	Crisis Walk-in	Disposition	# of individuals by disposition type	Disposition type	N	N	Could pull from other communities to define
1,2	Healthcare	Crisis Walk-in	# of referrals by source (self, friend, police, etc.)	# of individuals by referral source	Referral Source	N	N	Could pull from other communities to define
1,2	Healthcare	Crisis Walk-in	Insurance coverage	# of individuals by insurance type	Designated Insurance category - Health record	Some	Y	
1,2	Healthcare	Crisis Walk-in	# / % with high utilization	Total individuals with multiple admissions	Individuals with multiple admissions	N	N	
1,2	Healthcare	Crisis Walk-in	Service Capacity -Crisis walk in- capacity to service individuals (# chairs)	Total # of chairs	Chairs in crisis walk-in	N	Y	
1,2	Healthcare	Crisis Walk-in	Service Capacity -Crisis stabilization beds	Total # of beds	Beds in crisis walk-in	N	Y	
1,2	Healthcare	Crisis Walk-in	Average length of stay in crisis stabilization bed	Total of (Discharge date - admission date) / # admitted	Admission Date Discharge Date	N	Y	Could be claims based or from and EHR
1,2	Healthcare	Crisis Walk-in	Recidivism - repeat service within 30/60/90 days - % of individuals with repeat service in a crisis stabilization bed	# of individuals with repeat admissions within 30/60/90 days	Admissions	N	N	
2	Healthcare	Inpatient Facilities	In patient Psych Readmission rates	# of individuals with multiple inpatient psych claims / # of	Claims data with inpatient psych service code	Y	Y	This information should be available within hospital EMRs, although historical information would be needed. It can also be identified through claims. Most accurate
2	Healthcare	Inpatient Facilities or BH Provider	% Follow-up within 7 days	percentage of individuals with MEB issues that receive a follow call or service within 7 days	Inpatient stay data, follow-up service data with dates	N	Y	This is a standard measure for both hospitals and community providers per contract requirements. Would need to decide between hospitals and providers who is making these calls and how to collect (hospitals or community service provider)
2	Healthcare	Inpatient Facilities	# / % with high utilization	Total individuals with multiple admissions	Total individuals with multiple admissions	y	y	Community would need to agree on definition for high utilization (e.g. those with more than X inpatient stays within X months)
1	Healthcare	Inpatient Facilities	Adult psychiatric admissions;	count of the number of psychiatric services accessed	number of admits	Y	Y	Can be captured from longitudinal analysis from EMR systems
					services rendered across admits	y	y	can pull from claims data if deidentified
2	Healthcare	Inpatient Facilities	Timeliness of access to inpatient care – length of time waiting in ED	delay in transferring patient from an ED to a Inpatient facility/service	admit time into ED	N	N	While entrance into the ED is logged via triage centers, actual time to a bed is not available through front facing tools but could be derived from time stamp data
					Admit time into Inpatient bed or transfer to new hospital	N	N	Admit between bed times may not be available through front facing tool and thus into reports
1	Healthcare	Inpatient Facilities	Overall requests for BH inpatient beds (adults vs adolescents)?	count of requests for inpatient service	number of requests	N	N	may need a program to track this information as requests are received through a variety of mediums. Need to define a request and have a program to log the information
					results of that request	N	N	need a standard list of results to capture the result of an incoming request
1,2	Healthcare	Inpatient Facilities	Overall wait time for BH inpatient beds (adults vs adolescents)?	Time from request to time of available bed at any facility	time and date of request	N	N	
					service needed	N	N	wait times may vary by the service request and acuity, and this information will provide additional context for future analysis
					request solution identified	N	N	the solution may be identified before action can occur and a key measurement can also be when the resolution is put in place
					request resolution executed time and date	N	N	
					time and date of transfer/admit/discharge	N	N	
2	Healthcare	Inpatient Facilities	Average length of stay in an inpatient level of care	Total of (Discharge date - admission date) / # admitted	Admission Date Discharge Date	Y	Y	Could be claims based or from and EHR
2	Healthcare	Inpatient Facilities	Service Capacity -Inpatient beds	Total of # of beds	# of beds available	Y	Y	Requires calculation across inpatient facilities
2	Healthcare	ED	Average response time to BH individual in emergency room	Time from admit in ED to receiving service	admit date/time	Y	Y	An Emergency Department subgroup could develop how to standardize collection / reporting (e.g. use of indicators in EHR or claims data)

					Arrival time seen by healthcare professional	U	N	An Emergency Department subgroup could develop how to standardize collection / reporting (e.g. use of indicators in EHR or claims data)
1	Healthcare	ED	Referral sources	Total # of referral sources for each admit source complied	Admit Source	Y	N	An Emergency Department subgroup could develop how to standardize collection / reporting
2	Healthcare	ED	Average length of time to disposition out of emergency room for BH individual	Time from admit in ED to discharge	time/date of arrival time and date of discharge from ED	Y Y	N N	An Emergency Department subgroup could develop how to standardize collection / reporting
2	Healthcare	ED	Disposition	Total by disposition type	Discharge Disposition	Y	N	An Emergency Department subgroup could develop how to standardize collection / reporting
2	Healthcare	ED	Average response time to BH individual in emergency room (e.g. < 2 hours)	Time from admit in ED to receiving service	admit date/time time until doctor/psychologist evaluation	Y N	Y N	Emergency Department subgroup could develop how to measure (e.g. use of indicators in EHR or claims data) Emergency Department subgroup could develop how to measure (e.g. use of indicators in EHR or claims data)
2	Healthcare	ED	Average length of time to disposition out of emergency room for BH individual		time/date of arrival time and date of discharge from ED	Y Y	N N	Would need to differentiate between discharge and transfer from ED
2	Healthcare	ED	ED wait time to access in-patient psychiatric care	Average wait time in ED to transfer	Wait Time	N	N	Need to standardize how to measure unnecessary ED days when patients are waiting to be transferred to an inpatient bed. ED services are not the appropriate acuity level but this information needs to be captured in a uniform way within and across hospitals. Need to specify the reason for the delay in a transfer.
2	Healthcare	ED	ED wait time to access in-patient physical care	Average wait time	Wait Time	N	N	Need to standardize how to measure unnecessary ED days when patients are waiting to be transferred to an inpatient bed. ED services are not the appropriate acuity level but this information needs to be captured in a uniform way within and across hospitals. Need to specify the reason for the delay in a transfer.
2	Healthcare	ED	Disposition %	# of individuals per discharge type	Discharge Type	Y	N	
2	Healthcare	ED	# / % with high utilization	Total individuals with multiple admissions	Total individuals with multiple admissions with	N	N	Emergency Department subgroup could develop how to measure (e.g. use of indicators in EHR or claims data)
2	Healthcare	ED	Emergency room admissions for mental health, substance abuse, and crisis issues;	% of all ED admits with a MEB, substance, and crisis need	screen for mental health needs for all admits indicator for patients with a MEB need indicator for substance abuse for all patients (with or without a need) crisis indicator disposition list for all patients from a hospital list of ICD 10 issues for MEB, substance abuse, and crisis	Y Y Y Y Y	N N N N Y	Screening tools vary by hospital if implemented but may be able to use claims data to back into this information often described in notes but may not called out specifically with its own data point often described in notes but may not called out specifically with its own data point often described in notes but may not called out specifically with its own data point This information can be deidentified and at the aggregate level in many cases used to aggregate, may only capture the most pressing code not all conditions of the individual
1	Justice System	911 Dispatch	Calls to 911 where a behavioral health need was identified	total of calls with BH flag	R codes with MH indicator	Y	N	A subgroup could standardize how this data is collected in reports from 911 systems
1	Justice System	911 Dispatch	Number of MEB related crisis care calls coming into 911	Sum of MEB related calls across 911 call dispatch systems	CAD systems	Y	Y	Multiple different CAD systems need to be consolidated to get the total number or send in reports from disparate systems to gather the aggregate
1	Healthcare	911 Dispatch	Recidivism - repeat service within 30/60/90 days - % of individuals with repeat calls to 911	# of individuals with repeat calls to 911 within 30/60/90 days	Calls to 911	Y	Y	The data needed is captured and reports on numbers that call frequently and of those calls results will be helpful, especially if it highlights repeat MEB related issues within the community
2	Healthcare	911 Dispatch	Recidivism - repeat service within 30/60/90 days - % of individuals with repeat calls to 911 requiring police dispatch	# of individuals with repeat calls to 911 with police dispatch within 30/60/90 days	calls to 911 with police dispatch	Y	Y	The data needed is captured and reports on numbers that call frequently and of those calls results will be helpful, especially if it highlights repeat MEB related issues within the community and can help team better prepare for encounters
2	Healthcare	911 Dispatch	Recidivism - repeat service within 30/60/90 days - % of individuals with repeat calls to 911 requiring emergency services or fire	# of individuals with repeat calls to 911 requiring emergency services or fire within 30/60/90 days	calls to 911 requiring emergency services or fire	Y	Y	The data needed is captured and reports on numbers that call frequently and of those calls results will be helpful, especially if it highlights repeat MEB related issues within the community
1	Justice System	Law Enforcement	# of sworn officers who have completed CIT training	count of CIT training officer	CIT certifications	Y	Y	

1	Justice System	Law Enforcement	# of other law enforcement personnel who have completed CIT training?		CIT certifications	Y	Y	
1	Justice System	Law Enforcement	Number of calls police respond to in which the situation involves an individual or family with BH needs	count of incidents with individuals with MEB needs	Data point that a CIT officer is needed Data point to signify that the event requires BH needs be addressed Known address with BH needs	Y	N	This information can be collected in a variety of ways and the more centralized the location of the data point, the more accurate it can be (i.e. collecting and storing information in 1 system versus many)
1	Justice System	Law Enforcement	Number of MEB related citations (R-Code)	Count of MEB related R Codes across the county	Individuals with MEB conditions that call in	N	N	Calls may not tracked by individual but by address although they may relate to specific individuals with known MEB conditions. Storing and sharing this information can be helpful in preparing for an encounter. Need to build in a field, need someone to manage that field
		Law Enforcement			Addresses with known MEB needs calling in	N	N	Calls may not tracked by individual but by address although they may relate to specific individuals with known MEB conditions. Storing and sharing this information can be helpful in preparing for an encounter. Need to build in a field, need someone to manage that field (i.e. if people move)
		Law Enforcement			R codes associated with MEB issues	N	N	Need someone to flag the R Codes that have been associated with issues. R codes do not relate on a 1:1 basis for MEB instances, but there can be a correlation between some codes that may act as a proxy. Multiple R codes can be assigned to the same instance and a program would need to overcome these data quality issues.
1	Justice System	Law Enforcement	Capture where officer/deputy is taking individual – ER/Jail diversion	count of locations across incidents	Field in report of drop off location	N	N	Need to build in a field with the location drop off point, likely as a drop down to standardize the entries and then have that location categorized on the back end as Hospital, Jail, or other to improve reporting
		Law Enforcement			Field in report for drop off location type	N	N	Build a checkbox for hospitals, health care center, crisis center
1	Justice System	Jail	Identification and number of first time criminal justice offenders over all and for those with BH needs. (Overall provides a reference point)	comparison between past bookings and current bookings across a select time frame	list of past inmates with identifying information	U	Y	Would need to define the frequency with which to look at this data and data quality can be impacted by historical data transfer and technology system turnover.
					list of new inmates with identifiable information and a proven matching mechanism	U	Y	Would need to be done in the existing system, no outside program to capture this information
					Individuals with BH needs in the jail	Y	Y	
1	Justice System	Jail	Top one hundred inmates repeat bookings; overall and for those with BH needs (Overall provides a reference point)	100 individuals with the most bookings across the county	Count of jail bookings per person	Y	Y	Note: There are other ways to measure "Top" utilizers
					Booking durations or sentencing	Y	Y	Note: There are other ways to measure "Top" utilizers
1	Justice System	Jail	Inmate population with mental health, substance abuse, and crisis issues	% or list of inmates with mental health needs	Number of inmates on psychotropic drugs	Y	Y	If no MEB flag is within the program, consider adding it and the associated rules to it so that this data can more easily be pulled (i.e. if patient as an active prescription for a specific list of drugs then mark "MEB" check box should be automatically populated, but with a human override and reason code)
					high scores on select screening questions	Y	N	Establish a mental health screen that is not considered part of the health record and then have a scoring or flag that identifies individuals with BH need
					Past Screens from Probation for repeat offenders	Y	Y	Not captured in the shared program Service Point yet.
					Court screens from specialty court	Y	Y	Standard because there is a single entity, definitions need to be evaluated to applicability across organizations and sectors to see how they align
					ICD 10 discharge info related to mental health	Y	Y	Information is made available upon request. Armor can reach out for the information but there is no system whereby the hospital sends the information automatically upon learning of a booking and information is often sent via fax which is not the most efficient way to share information.
1	Justice System	Jail	Mental Health Specialty Court recidivism	count individuals that have repeated offenses in Specialty Court	personal identifiable information per person	Y	Y	the PII information is standardized because there is a single entity. If this information was shared across organizations, there would need to be a matching mechanism to standardize the input and align for common participants or clients.

					mental health court flag per cases	Y	Y	
					cases by person	Y	Y	the CRIMS data base was originally organized by cases (unique case number instead of individual identifiers) and has recently moved to a person focused program where by the number of cases per person can be identified however the process for doing so is a bit complicated, therefore there are some data quality concerns that may need to be addressed if this information were to be pulled on a larger scale and systemically.
1	Justice System	Jail	services/care ordered by specialty court / probation	count of the number of each service ordered by the courts	standardized list of services	U	Unknown	
					unique field per service	U	Unknown	if directions are in all text fields, extracting this information could be difficult
1	Justice System	Jail	Recidivism - repeat service within 30/60/90 days - % of individuals with repeat jail bookings	# of individuals with repeat jail bookings within 30/60/90 days	jail bookings			
3	Justice System	Probation	Individual status/progress	progress towards individualized plans	Definition of progress	U	U	Progress definitions and milestones to be agreed upon and standardized.
					standardized expectation milestones per type of case - length of time expected per milestone	U	U	Progress definitions and milestones to be agreed upon and standardized.
					individual timelines - personal factor for time (language barriers, severity of need, support network etc.)	U	U	degree of flexibility and customization may be needed for select individuals
					definition of successfully completing a milestone	U	U	Progress definitions and milestones to be agreed upon and standardized.
2	Justice System	Probation	Availability of services	services and waitlist times at commonly referred to programs	average waitlist time per organization	N	N	Feedback loop to provide probation with the time it can take to access needed services so that probation can plan accordingly and help probationer schedule appointments more easily thus enhancing their chance at showing up at an appointment and success
2	Justice System	Probation	Appointment adherence	appointment adherence	known appointment times at recommended service providers and status of the appointment (Cancelled, attended, pending)	N	N	Need to establish a feedback loop that informs care team of this information to identify areas of intervention where services and attention may be needed
1	Justice System	Probation	Known housing stability	length of time at a single address	last known address and length of time at that address	Y	Y	Difficult to capture if individuals are not forth coming with information or with a nomadic individual.
1	Justice System	Probation	Prevalence of behavioral health needs for probationers	Total number of records in the probations data system that have the behavioral health flag checked	Behavioral Health flag	Y	N	Probation to identify if they are leady have a data point reflecting this measure or identify how they can collect this data
3	Community	Homeless	Individuals seeking homeless services	Total of those seeking services	Date of entry for homeless services	Y	Y	Data collected and reported for housing coalition
3	Community	Service Capacity - Housing Support	# capacity/availability for shelter, temporary or permanent	Currently available housing options by category	types of housing available 'fit' measurements for individuals to ensure a correct match	Y	Y	Information is available and understood to be largely universal across organizations. Standards change frequently however which can make longitudinal analysis difficult and it poses some data quality concerns.
3	Community	Service Capacity - Housing Support	# capacity / availability of supportive housing	Currently available housing options by category		Y	Y	
3	Community	Homelessness	Total Number of Persons who Exited to Permanent Housing	Total number of homelessness individuals who found and returned to permanent housing	Individual name and housing status permanent housing placement and length of time in housing	Y	Y	This data is important for outcome measurements and can help care networks to track progress. It does require frequent check-ins however to ensure that the last status on file is still accurate, which may require additional operational resources to conduct.
3	Community	Homelessness	Number Returning to Homelessness in Less than 6 Months	number of homeless individuals that return for housing support within 6 months	Individual name and housing status	Y	Y	The data quality of this information is dependent on having collected information at the start and then again afterwards.
3	Community	Homelessness	Number of Returns in 2 Years	Number of homeless individuals that return for housing support within 2 years	Individual name and housing status	Y	Y	Documentation of individuals history within the housing support system. If individual has sought help from multiple locations, locations will benefit from having a shared system.

3	Community	Homelessness	Number homeless individuals with MEB conditions staying with family	Number homeless individuals with MEB conditions staying with family	Individual name and housing status MEB screen score Presence and availability of nearby family, relatives, or friends	Y	Y	This data is documented on in take forms but is subject to change frequently, However the documentation of family support services can help assist others in the care network to understand the full patient need.
3	Community	Homelessness	Need for housing services	count of individuals' housing needs	standardize definition of factors of need	Y	y	Information is available and understood to be largely universal across organizations. Standards change frequently however which can make longitudinal analysis difficult and it poses some data quality concerns.
					Standardized approach for measuring needs across the county	Y	y	Information is available and understood to be largely universal across organizations. Standards change frequently however which can make longitudinal analysis difficult and it poses some data quality concerns.
					standardized list of the factors of need	Y	y	Information is available and understood to be largely universal across organizations. Standards change frequently however which can make longitudinal analysis difficult and it poses some data quality concerns.
					standardized list of housing needs	y	y	Information is available and understood to be largely universal across organizations. Standards change frequently however which can make longitudinal analysis difficult and it poses some data quality concerns.
All	Public Health	Public Health	Trends in the general pop. vs MEB pop as it relates to Housing	Multiple	Multiple	U	U	Community to decide on the population health trends most impactful to analyze over time
All	Public Health	Public Health	Trends if the general pop. vs MEB pop as it relates to Employment	Multiple	Multiple	U	U	Community to decide on the population health trends most impactful to analyze over time
All	Public Health	Public Health	Trends in the general pop. vs MEB pop as it relates to Education	Multiple	Multiple	U	U	Community to decide on the population health trends most impactful to analyze over time
All	Public Health	Public Health	Trends in the general pop. vs MEB pop as it relates to avoidance of justice involvement	Multiple	Multiple	U	U	Community to decide on the population health trends most impactful to analyze over time
All	All	All	Recidivism - repeat service within 30/60/90 days - % of individuals with repeat service to any of the aforementioned services	# of individuals with repeat admissions within 30/60/90 days	PII from all organizations	Y	N	PII may not be available from all organizations, but of those that can share it, it provides additional transparency into, at a minimum the types of services a patient is receiving.
All	All	All	Utilization shift from ED services to community services	concurrent trends across measurements in each sector or individual tracking trends (if available)	Differential in the services individuals are seeking Differential in the services provided between organizations	N	N	Explore use of claims data to have aggregated data on different service code utilization (compare ED codes use to community code use)

## Data Matrix

This Data Matrix is intended to highlight how data measurements can be reached with existing or new data points and/or agreements and protocols. The purpose of providing this matrix is to brainstorm data that can be used to support key decisions. To support on-going decision making, programs and continuous data sharing on a set frequency would need to be established. This list does not include all of the data measurements or points that *could be* shared nor is this matrix a list of all the data points that *will be* shared.

Furthermore, this list does not suggest that it is possible or easy to share select data points, it is simply a tool to surface and raise awareness of the data that would be most impactful for decision making.

The data below is what has been collected or brainstormed to date and is subject to change.

<b>Key Decision Legend:</b>	<b>needs of those accessing behavioral care</b>	<b>Impacting outcomes and making a difference for individuals and families</b>
<b>1 - Who is in need of or seeking behavioral health care</b>		

Key Decisions	Sector (s)	Provider Type within Sector	Data Measurement	Calculation (if needed)	Data Point	Available	Standard-ized	Comments and Potential Barrier to overcome
1	Healthcare	BH Provider	Individuals are receiving BH services (over the past month)	Total of behavioral health record with an initial service date but no close date (pulled the first or last data of the month)	Initial service date Close service date or Count service visits/encounters using claims data	N	N	BH Provider subgroup to agree on measure standardization Depending on the data sharing model selected, this could be capture through reports sent in by Providers or could be capture through a central repository
1	Healthcare	BH Provider	Individuals are receiving BH services (over the past month) <b>by payor</b>	Total of behavioral health record with an initial service date but no close date (pulled the first or last data of the month) by payor source	Initial service date Close service date Payor source or Count service visits/encounters using claims data	Y	N	BH Provider subgroup to agree on measure standardization Depending on the data sharing model selected, this could be capture through reports sent in by Providers or could be capture through a central repository
1	Healthcare	BH Provider	<b>NEW</b> individuals/families are accessing BH services (over the past month)?	Total of behavioral health record with an initial service date that falls within the last month	Initial service date or New patients using claims data	N	N	BH Provider subgroup to agree on measure standardization Depending on the data sharing model selected, this could be capture through reports sent in by BH Providers or could be capture through a central repository
1	Healthcare	BH Provider	Demographics	Total # of individuals by zip code	Zip code	Y	Y	
1	Healthcare	BH Provider	Referral sources	Total # of referral sources for each admit source complied	Referral Source	Y	N	
1	Healthcare	BH Provider	Behavioral health conditions (including MH and BH)	# of individuals with dx	Diagnosis	Y	Y	
1	Healthcare	BH Provider	Co-occurring MH /SA	# of individuals with BH and SA diagnosis	Diagnosis	Y	Y	
1	Healthcare	BH Provider	Physical health conditions	# of individuals with physical health dx	Diagnosis	Y	Y	
1	Healthcare	BH Provider	Functioning level	# of individual per functioning level	Functioning scores	Y	N	BH group to explore and make decisions about what standardized functioning scores to use (e.g.. Consider functioning scores that are required by state for submission upon entry and exit of services)
1	Healthcare	BH Provider	Functioning level by special population	# of individual per functioning level with special population flag	Functioning scores Special populations flag	Y	N	BH group to explore and make decisions about what standardized functioning scores to use (e.g.. Consider functioning scores that are required by state for submission upon entry and exit of services)
2	Healthcare	BH Provider	Timeliness of routine services - for an Assessment	Average length of time for an appointment	Date of service request Date of appointment	Some providers	N	BH Provider subgroup to agree on measure standardization
				% that are within 7 days	Date of service request Date of appointment	Some providers	N	BH Provider subgroup to agree on measure standardization
2	Healthcare	BH Provider	Timeliness of routine services - for a medication assessment	Average length of time for an appointment	Date of service request Date of appointment	Some providers	N	BH Provider subgroup to agree on measure standardization
				% that are within 7 days	Date of service request Date of appointment	Some providers	N	BH Provider subgroup to agree on measure standardization
2	Healthcare	BH Provider	Timeliness of routine services - for access to on-going treatment	Average length of time for an appointment	Date of service request Date of appointment	Y	Y	If not available in user-facing programs, available as time stamp data within the scheduling software.
						Y	Y	
2	Healthcare	BH Provider	Timeliness of routine services - for support services (e.g. living	Average length of time for an appointment	Date of service request Date of appointment	Y	Y	If not available in user-facing programs, available as time stamp data within the scheduling software.
						Y	Y	
2	Healthcare	Service length of time	Average length of service duration for routine services	Total of (Date of entering services - current date in days) /	Date of entering services	Y	Y	If not available in user-facing programs, available as time stamp data within the scheduling software.
				# of individuals actively receiving services		# of individuals actively receiving services	N	
1	Healthcare	BH Provider	Service Capacity -	# psychiatrists/NP, PA	# psychiatrists/NP, PA	Y	Y	

			Routine Services - # psychiatrists/NP, PA per 100,000 lives	per 100,000 lives	# of MEB lives	Y	Y	an use a proxy such as an estimation based on national best practices May need to confirm definition across organizations relative to the services provided to have a standardized criteria for the population
2	Healthcare	BH Provider	Service Capacity - Routine Services- # of BH Professional providers per 100,000	Professional availability : covered lives	# of BH Professional providers # of MEB lives	N N	N N	BH group to define the list to include in professional lives BH group to define how to identify these individuals across programs or to use proxies based on population data
2	Healthcare	BH Provider	Service Capacity - Routine Services - # of certified peer support specialists per 10,000 lives	Peer support : covered lives	# of certified peer support specialists # of MEB lives	Y Y	N N	This information is likely known within each organization, but definitions should be compared across the community to arrive at a system level calculation and ensure high data quality This information may be defined within each organization but it needs to be defined across the community as well.
2	Healthcare	BH Provider	Service Capacity - Routine Services- # of certified family support specialists per 10,000 lives	family support : covered lives	# of certified family support specialists # of MEB lives	Y Y	N N	This information is likely known within each organization, but definitions should be compared across the community to arrive at a system level calculation and ensure high data quality This information may be defined within each organization but it needs to be defined across the community as well.
1,2	Healthcare	Crisis Call Center	Volume (Daily, monthly)	Total call volume for a month / # days in month	Call volume	Y	U	No universal number for a crisis center across the county
1,2	Healthcare	Crisis Call Center	Recidivism - repeat service within 30/60/90 days	# of individuals with repeat calls within 30/60/90 days	% of individuals with repeat calls to the crisis line	N	N	program to measure call statistics including; caller source, incoming call time, time to answer, call duration, abandonment rates etc.
1,2	Healthcare	Crisis Walk-in	Volume (Daily, monthly)	Total # of admissions	Admissions	N	N	
1,2	Healthcare	Crisis Walk-in	Recidivism - repeat service within 30/60/90 days - % of individuals with repeat service in a crisis stabilization bed	# of individuals with repeat admissions within 30/60/90 days	Admissions	N	N	
2	Healthcare	Inpatient Facilities	In patient Psych Readmission rates	# of individuals with multiple inpatient psych claims / # of	Claims data with inpatient psych service code	Y	Y	This information should be available within hospital EMRs, although historical information would be needed. It can also be identified through claims. Most accurate
1	Healthcare	Inpatient Facilities	Overall requests for BH inpatient beds (adults vs adolescents)?	count of requests for inpatient service	number of requests results of that request	N N	N N	may need a program to track this information as requests are received through a variety of mediums. Need to define a request and have a program to log the information need a standard list of results to capture the result of an incoming request
1,2	Healthcare	Inpatient Facilities	Overall wait time for BH inpatient beds (adults vs adolescents)?	Time from request to time of available bed at any facility	time and date of request service needed request solution identified request resolution executed time and date time and date of transfer/admit/discharge	N N N N N	N N N N N	wait times may vary by the service request and acuity, and this information will provide additional context for future analysis the solution may be identified before action can occur and a key measurement can also be when the resolution is put in place
2	Healthcare	Inpatient Facilities	Average length of stay in an inpatient level of care	Total of (Discharge date - admission date) / # admitted	Admission Date Discharge Date	Y	Y	Could be claims based or from and EHR
2	Healthcare	Inpatient Facilities	Service Capacity - Inpatient beds	Total of # of beds	# of beds available	Y	Y	Requires calculation across inpatient facilities
1	Healthcare	ED	# Individuals accessing care at ED	Total of admissions with DX of BH	# of admissions DX for behavioral health	Y	N	
1	Healthcare	ED	# of individuals by payor source	Total of admissions with DX of BH by payor source	# of admissions DX for behavioral health payor	Y	N	
1	Healthcare	ED	BH Conditions seeking services for	Total admissions by BH DX	# of admissions DX for behavioral health	Y	N	

1	Healthcare	ED	Co-occurring physical health conditions	Total admissions by physical health condition for those with BH DX	# of admissions DX for behavioral health	Y	N	
2	Healthcare	ED	Average response time to BH individual in emergency room	Time from admit in ED to receiving service	# of admissions DX for behavioral health			
					Arrival time seen by healthcare professional	U	N	An Emergency Department subgroup could develop how to standardize collection / reporting (e.g. use of indicators in EHR or claims data)
1	Healthcare	ED	Referral sources	Total # of referral sources for each admit source complied	Admit Source	Y	N	An Emergency Department subgroup could develop how to standardize collection / reporting
1	Healthcare	ED	Demographics		Zip code			
2	Healthcare	ED	Average length of time to disposition out of emergency room	Time from admit in ED to discharge	time/date of arrival	Y	N	An Emergency Department subgroup could develop how to standardize collection / reporting
					time and date of discharge from ED	Y	N	
2	Healthcare	ED	Disposition	Total by disposition type	Discharge Disposition	Y	N	An Emergency Department subgroup could develop how to standardize collection / reporting
2	Healthcare	ED	ED wait time to access in-patient psychiatric care	Average wait time in ED to transfer	Wait Time	N	N	Need to standardize how to measure unnecessary ED days when patients are waiting to be transferred to an inpatient bed. ED services are not the appropriate acuity level but this information needs to be captured in a uniform way within and across hospitals. Need to specify the reason for the delay in a transfer.
2	Healthcare	ED	# / % with high utilization	Total individuals with multiple admissions	Total individuals with multiple admissions with psych DX	N	N	Emergency Department subgroup could develop how to measure (e.g. use of indicators in EHR or claims data)
1	Justice System	Law Enforcement	# of sworn officers who have completed CIT training	count of CIT training officer	CIT certifications	Y	Y	
1	Justice System	Law Enforcement	# of other law enforcement personnel who have completed CIT training?		CIT certifications	Y	Y	
1	Justice System	Jail	# of jail personnel who have completed CIT training	count of CIT training for jail personnel	CIT certifications	?	?	
1	Justice System	Jail	Inmate population with mental health, substance abuse, and crisis issues	% or list of inmates with mental health needs	Number of inmates on psychotropic drugs	Y	Y	If no MEB flag is within the program, consider adding it and the associated rules to it so that this data can more easily be pulled (i.e. if patient as an active prescription for a specific list of drugs then mark "MEB" check box should be automatically populated, but with a human override and reason code)
					high scores on select screening questions	Y	No	Establish a mental health screen that is not considered part of the health record and then have a scoring or flag that identifies individuals with BH need
					Past Screens from Probation for repeat offenders	Y	Y	Not captured in the shared program Service Point yet.
					Court screens from specialty court	Y	Y	Standard because there is a single entity, definitions need to be evaluated to applicability across organizations and sectors to see how they align
					ICD 10 discharge info related to mental health	Y	Y	Information is made available upon request. Armor can reach out for the information but there is no system whereby the hospital sends the information automatically upon learning of a booking and information is often sent via fax which is not the most efficient way to share information.
1	Justice System	Jail	Recidivism - repeat service within 30/60/90 days - % of individuals with repeat jail bookings	# of individuals with repeat jail bookings within 30/60/90 days	jail bookings			
1	Justice System	Probation	Prevalence of behavioral health needs for probationers	Total number of records in the probations data system that have the behavioral health flag checked	Behavioral Health flag	Caseload Explorer	N	Probation to identify if they are leady have a data point reflecting this measure or identify how they can collect this data

## Appendix 7.12: Systemic Questions to Prioritize – Workshop 1

# Using Data to Answer Systemic Questions: What do we want to know or could we know about Behavioral Healthcare Delivery and Outcomes in Lake County?

Many communities use data to support their future planning, for measuring needs and identifying if goals are being realized. Within the healthcare and behavioral health field, this is also the case. Many government entities, insurance / managed care companies, accountable care organizations and other similar entities use data for such tasks as planning, managing the health of populations and evaluating outcomes. These entities will look to *aggregated data* to accomplish planning and oversight of the care delivery system.

Although there is no one standardized list of questions to be addressed or formulas to answer questions, there is a theme in how entities approach using data to inform the future and decisions.

They use a combination of different aggregated data points to tell a story in which inferences and conclusions can be drawn. It's a combination of science, art and experience. Communities have organized themselves in ways to *continuously* (not a one-time look) answer a set of priorities questions at specified intervals in order to support their planning and oversight.

Three predominate themes have surfaced regarding information desired by Coalition Members and stakeholders to support future planning and provide oversight of the behavioral healthcare delivery system.

- **Who is in need of or seeking behavioral health care?**
  - **What are their overall service needs?**
  - **What is the System Delivery for those needs?**
  
- **Are the service needs of those accessing behavioral care being met?**
  
- **Are the services provided impacting outcomes and making a difference for individuals and families served?**

There are many more specific questions that can be asked related to the aforementioned, predominate themes of information desired. Following are *examples* of more detailed questions related to each of the prior themes.

**Appendix 7.12: Systemic Questions to Prioritize – Workshop 1**  
**Using Data to Answer Systemic Questions:**  
**What do we want to know or could we know about**  
**Behavioral Healthcare Delivery and Outcomes in Lake County?**

For individuals with mental emotional or behavioral health needs

**Who is in need of or seeking behavioral health care?**

- What are the demographics of those seeking services?
- What are the functioning levels for individuals/families seeking services?
- What is known about the social determinates of health for those seeking services (e.g. income, education, job security, childhood development, food security, housing, social connectedness, neighborhood environment, expose to or involved in criminal activity, environmental stressors, experience of trauma)?
  - What is known overall about the general population compared to those with mental health needs as it related to social determinates?
- What are the co-occurring physical health conditions for individuals seeking services?

**What are their overall service needs?**

- How many individuals/families are receiving services (over the past month)?
- How many new individuals/families are accessing services (over the past month)?
- What behavioral health conditions are individuals/families seeking services for (e.g. relationship problems, psychosis, depression, suicidal thoughts/actions, substance abuse/dependence, anxiety, etc.)?
- In the aggregate, what are the overall service intensity needs of the individuals/families (e.g. high, medium, low intensity need)?
  - By special populations (e.g. justice involved, SMI) what are the overall service intensity needs by individuals/families?
  - What types of services are needed to address the overall service needs of those accessing services (e.g. medication assessment/monitoring, treatment services such as counseling, support services such as living skills, peer/family support)?
- Do individuals/families have access to the most appropriate level of service or do they have to access services at high levels of care then what they need?
  - Are special populations accessing care (e.g. those who enter jail, probationers, parolees, homeless, families interacting with child welfare)?

## Appendix 7.12: Systemic Questions to Prioritize – Workshop 1

### Using Data to Answer Systemic Questions:

## What do we want to know or could we know about Behavioral Healthcare Delivery and Outcomes in Lake County?

▪

### What is the System Delivery for those needs?

- Who are the system partners referring to the aforementioned level of care (e.g. self-referral, police, fire, schools, homeless provider, probation, religious organization, employer, etc.)?
- What is the level of demand by these system partners?
  - What volume of calls to 911 are behavioral health related?
  - What volume of calls that police respond to are behavioral health related?
  - How many individuals in jail have behavioral health needs?
  - How many probationers have behavioral health needs?
  - How many families with children in the care and custody of the state who have behavioral health needs?
- Where are individuals/families accessing care
  - Community based behavioral health care
  - Crisis level of care
    - Crisis line
    - Mobile team
    - Crisis walk-in care
  - Emergency Department
- What progress is being made in information the community about behavioral health services?
  - How many trainings are being offered for Mental Health First Aid Training?
  - How many individuals are trained in Mental Health First Aid?
  - How many “In Our Own Voice” trainings are being provided?

### Are the service needs of those accessing behavioral care being met?

- **Timelines of services**
  - Are emergent, urgent and routine services provided in a timely manner?
    - Are **routine services** provided within a pre-determined standard
      - Within 7 days for an assessment by a BH professional
      - Within 7 days for a medication assessment by a BH health care professional
      - Within X days for on-going treatment services (e.g. counseling)

## Appendix 7.12: Systemic Questions to Prioritize – Workshop 1

### Using Data to Answer Systemic Questions:

## What do we want to know or could we know about Behavioral Healthcare Delivery and Outcomes in Lake County?

- Within X days for support services (e.g. living skills)
- Within X days for accessing peer / family support services
- Warmline calls (peer to peer support line) answered within X seconds
- Nurse Support line answered within X seconds
- Are **urgent services** provided within a pre-determined standard?
  - Crisis calls answered within X seconds (average speed of answer)
    - Calls transferred from 911 are answered within X seconds
    - Calls from police answered within X seconds
    - Calls from Emergency Departments answered within X seconds
    - Calls from Jails answered within X seconds
  - Mobile teams respond to individuals/families within X timeframe
    - Average response to individuals/families in the community
    - Average response time to law enforcement request for assistance in the community
    - Average response to individuals in an Emergency Department
  - Crisis walk-in services are provided within X minutes
    - Drop off by police are provided within X minutes
- Are emergency services provided within a pre-determined standard?
  - Average length of time to access in-patient psychiatric care
  - Average length of time an individual waits in an ED for in-patient care
- Is follow-up care being provided in accordance with a pre-determined standard for those accessing urgent and emergency services?
  - Average length of time for follow-up to an emergent service?
  - Average length of time for follow-up to an urgent service?
- **Service Capacity**
  - *Routine services* - Behavioral healthcare medical, BH professional, support capacity
    - # psychiatrists/NP, PA per 100,000 lives

## Appendix 7.12: Systemic Questions to Prioritize – Workshop 1

### Using Data to Answer Systemic Questions:

## What do we want to know or could we know about Behavioral Healthcare Delivery and Outcomes in Lake County?

- # of BH Professional providers per 100,000 (e.g. licensed SW, Counselor, MH therapist, SA providers)
- # of certified peer support specialists per 10,000 lives
- # of certified family support specialists per 10,000 lives
  
- *Urgent/emergency services* –
  - Behavioral health mobile team capacity (# of teams per day)
  - Crisis walk in- capacity to service individuals (# chairs)
  - Crisis stabilization beds
  - Inpatient bed
  
- *Employment Support*
  - # capacity/availability for employment supportive services
  
- *Housing Support*
  - # capacity/availability for shelter, temporary or permanent
  - # capacity / availability of supportive housing
  
- **Service length of time**
  - Average length of service duration for routine services
  - Average length of stay in crisis stabilization bed
  - Average length of stay in an inpatient level of care
  
- **Recidivism - repeat service within 30/60/90 days**
  - % of individuals with repeat calls to the **crisis line**
  - % of individuals with repeat service in a **crisis stabilization bed**
  - % of individuals with repeat service in an **inpatient psychiatric stay**
  - % of individuals with repeat service in an **Emergency Department**
  - % of individuals with repeat calls to **911**
  - % of individuals with repeat calls to **911 requiring police dispatch**
  - % of individuals with repeat calls to **911 requiring emergency services or fire**
  - % of individuals with repeat **jail bookings**
  
  - % of individuals with repeat service to any of the aforementioned sectors
  
- **Risk and health assessment scores**
  - HEDIS measures
  - Risk measures
  - Protective Factor measures
  
- **Care Management**

## Appendix 7.12: Systemic Questions to Prioritize – Workshop 1

### Using Data to Answer Systemic Questions:

## What do we want to know or could we know about Behavioral Healthcare Delivery and Outcomes in Lake County?

- What # / % of individuals are assigned to a care management program for those with medium to high levels of care needs
- # of new individuals be assigned to care management program
- # of individuals removed from care management program (by reducing service needs or for lack of contact after outreach)
- For those assigned to care management,
  - # with justice involvement
  - Other special population characteristics
  
- **Shift in service utilization**
  - Is the service utilization for the different types of services changing to reflect individuals/ families using more community services rather than high cost emergency services?
    - Service utilization for acute services
    - Service utilization for crisis services
    - Service utilization for routine BH services
      - Medical provider for medications
      - Treatment services - BH professionals - counseling
      - Support services like skills training
  
- **Law Enforcement Preparedness to Respond to Individuals/Families**
  - Number of sworn officers who have completed CIT training?
  - Number of other law enforcement personnel who have completed CIT training?

### Are the services provided impacting outcomes and making a difference for individuals and families served?

- For those who have accessed services:
  - Is their life functioning improved over time?
    - stable housing,
    - improved relationships,
    - meaningful daily activity (work, school, volunteer),
      - (e.g. employment duration for those with severe mental illness)
    - effectively managing their mental health,
    - effectively managing substance abuse, and
    - avoiding justice involvement.

## Appendix 7.12: Systemic Questions to Prioritize – Workshop 1

# Using Data to Answer Systemic Questions: What do we want to know or could we know about Behavioral Healthcare Delivery and Outcomes in Lake County?

- What is known overall for the general population compared to those with mental health needs as it related as it relates to
  - Housing
  - Employment
  - Education
  - Avoidance of justice involvement
  
- For those who have accessed services:
  - Is there ability to manage their mental health improved?
  - Is there ability to manage any physical health conditions improved?
  
- For those who have accessed services:
  - Are jail diversion strategies being employed?
    - Use of crisis services
      - # use of mobile teams
      - # use of crisis walk-in
  
- **Satisfaction Survey Results (are services provided impacting outcomes)**
  - Are individuals / families satisfied with their services?
  - Did the service system address their behavioral health service needs?
  - Did the service system address or connect them with other social services needed?
  - Where services delivered in a setting that addressed their needs?
  - Where service providers respectful of their cultural needs?

**Using Data to Answer Systemic Questions:  
Prioritizing What do we want to know or could we know about  
Behavioral Healthcare Delivery and Outcomes in Lake County?  
Part 2**

This document is a continuation of the *Using Data to Answer Systemic Questions: What do we want to know or could we know about Behavioral Healthcare Delivery and Outcomes in Lake County?* document provided to the Lake County Mental Health Coalition on August 21, 2017. The prior document outlined three predominate themes of systemic questions that could be answered followed by a more detailed list of specific questions that would be asked related to the three themes. To fully understand what is being conveyed herein, the prior document should be reviewed.

### **Prioritized Approach**

Based on the prior review of current state assessment and information gleaned from the MH Coalition, *the following is one approach to prioritizing systemic questions.*

**Prioritize as an initial strategy to answer a subset of questions for the first two themes:**

- **Who is in need of or seeking behavioral health care?**
  
- **Are the service needs of those accessing behavioral care being met?**

At a later time, further develop additional data sets that address the prior themes as well as answers the final theme.

- **Are the services provided impacting outcomes and making a difference for individuals and families served?**

Following are examples of more detailed questions that could be prioritized initially related to the first two themes. The information is presented in accordance with the sector that possibly could provide the information in aggregated format.

**Using Data to Answer Systemic Questions:  
Prioritizing What do we want to know or could we know about  
Behavioral Healthcare Delivery and Outcomes in Lake County?  
Part 2**

**I. Community based providers who provide behavioral health services (inclusive of all mental health and substance abuse needs and treatment)**

Community based behavioral health providers could provide information in aggregated form to answer the following system questions.

**Who is in need of or seeking behavioral health care?**

- How many individuals/families are receiving services (over the past month)?
  - By payor source
- How many new individuals/families are accessing services (over the past month)?
  - By payor source
- Who are the system partners referring to the aforementioned level of care (e.g. self-referral, police, fire, schools, homeless provider, probation, religious organization, employer, etc.)?
- What are the demographics (e.g. zip code) of those seeking services?
- What behavioral health conditions are individuals/families seeking services for (e.g. relationship problems, psychosis, depression, suicidal thoughts/actions, substance abuse/dependence, anxiety, etc.)?
- What are the co-occurring physical health conditions for individuals seeking services?
- What are the co-occurring mental and substance abuse conditions for individuals seeking services?
- In the aggregate, what are the overall service intensity needs of the individuals/families (e.g. high, medium, low intensity need)?
  - By special populations (e.g. justice involved, SMI) what are the overall service intensity needs by individuals/families?

**Are the service needs of those accessing behavioral care being met?**

**Using Data to Answer Systemic Questions:  
Prioritizing What do we want to know or could we know about  
Behavioral Healthcare Delivery and Outcomes in Lake County?  
Part 2**

- **Timelines of services**
  - Are **routine services** provided within a pre-determined standard
    - Within 7 days for an assessment by a BH professional
    - Within 7 days for a medication assessment by a BH health care professional
    - Within 23 days for on-going treatment services (e.g. counseling)
    - Within 23 days for support services (e.g. living skills)
- **Service length of time**
  - Average length of service duration for routine services
- **Recidivism - repeat service within 30/60/90 days**
  - % of individuals with repeat calls to the **crisis line**
  - % of individuals with repeat service in a **crisis stabilization bed**
  - % of individuals with repeat service in an **inpatient psychiatric stay**
- **Service Capacity**
  - *Routine services* - Behavioral healthcare medical, BH professional, support capacity
    - # psychiatrists/NP, PA per 100,000 lives
    - # of BH Professional providers per 100,000 (e.g. licensed SW, Counselor, MH therapist, SA providers)
    - # of certified peer support specialists per 10,000 lives
    - # of certified family support specialists per 10,000 lives

## II. Emergency Departments

Emergency Departments could provide information in aggregated form to answer the following system questions.

### Who is in need of or seeking behavioral health care?

#### **Identifying individuals/families seeking services within Emergency Departments**

- How many individuals/families are accessing care for behavioral health needs at an Emergency Room?
  - By payor source

## Appendix 7.13: Systemic Questions to Prioritize – Workshop 2

### Using Data to Answer Systemic Questions:

## **Prioritizing** What do we want to know or could we know about Behavioral Healthcare Delivery and Outcomes in Lake County? Part 2

- Who are the system partners referring to the Emergency Departments (e.g. self-referral, police, fire, schools, homeless provider, probation, religious organization, employer, etc.)?
- What are the demographics (e.g. zip code) of those seeking services?
- What behavioral health conditions are individuals/families seeking services for (e.g. relationship problems, psychosis, depression, suicidal thoughts/actions, substance abuse/dependence, anxiety, etc.)?
- What are the co-occurring physical health conditions for individuals seeking services?
- Where was the individual discharged to (e.g. home, group home, inpatient care)?

### Are the service needs of those accessing behavioral care being met?

- **Time in Emergency Departments**
  - Length of time to access care
  - Length of time to disposition
    - By payor
    - By disposition placement (e.g. home, group home, inpatient care)
- **Recidivism - repeat service within 30/60/90 days**
  - % of individuals with repeat service in an **Emergency Department**

### III. Behavioral Health Inpatient Psychiatric Hospitalization

#### Who is in need of or seeking behavioral health care?

- How many individuals are accessing inpatient care receiving services (over the past month)?
  - By payor source
  - By age
- What is the wait time to access a Bed?
- What are the re-admission rates of accessing inpatient care?

### IV. 911 Dispatch

**Using Data to Answer Systemic Questions:  
Prioritizing What do we want to know or could we know about  
Behavioral Healthcare Delivery and Outcomes in Lake County?  
Part 2**

**911 Dispatch Preparedness to Respond to Individuals/Families**

- Total Number of 911 personnel who have completed CIT training?
- # of recent graduates from CIT training

**V. Police**

**Law Enforcement Preparedness to Respond to Individuals/Families**

- Total number of sworn officers who have completed CIT training?
- # of recent graduates from CIT training

**VI. Jails**

**Who is in need of or seeking behavioral health care?**

- # of individuals entering jail a behavioral health need
- # of individuals with repeat bookings that have a behavioral health need

**Jail Personnel Preparedness to Respond to Individuals/Families**

- Total Number of jail personnel who have completed CIT training?
- # of recent graduates from CIT training

**VII. Probation**

**Who is in need of or seeking behavioral health care?**

- # of individuals on probation with an identified behavioral health need

**VIII. Housing**

**Who is in need of or seeking behavioral health care?**

Explore with Housing Coalition which reports could be useful to share with MH Coalition to address priorities questions.

## Appendix 7.14: Glossary of Acronyms

### Glossary of Acronyms

**ACA** – Affordable Care Act

**ADT** – Admissions, Discharge, and Transfers information

**BAA** – Business associated agreement

**BH** – Behavioral Health

**BHL** – Behavioral Health Link

**BI** – Business Intelligence

**CAD** – Computer-Aided Dispatch

**C-CDA** – Consolidated Clinical Document Architecture

**CCMN** –Community Care Management Network

**CIT** – Crisis Intervention Team

**CRIMS** – Criminal Records Information Management System

**DD** – Dual Diagnosis

**DDCFT** – Dual Diagnosis Cross Functional Team

**DG** – Data Governance

**DW** – Data Warehouse

**E&T** – Evaluation and Treatment

**ED** – Emergency Department

**EDIE** – Emergency Department Information Exchange

**EHR** – Electronic Health Record

**EMR** – Electronic Medical Record

**ETL** – Extract, Transform, Load

**ESB** – Enterprise Service Bus

**FTE** – Full-Time Equivalent

**HEDIS** – Healthcare Effectiveness and Information Set

**HIE** – Health Information Exchange

**HIO** - Health Information Organization

**HIPAA** – Health Insurance Portability and Accountability Act

**HISP** – Health Information Service Provider

## Appendix 7.14: Glossary of Acronyms

**HITECH** – Health Information Technology for Economic and Clinical Health

**HL7** – Health Level-7

**HMIS** – Homeless Management Information System

**ICD** – International Classification of Diseases

**IDS** – Integrated Data System

**JIMS** – Justice Information Management System

**MCO** – Managed Care Organizations

**MDM** – Master Data Management

**MOU** – Memorandum of Understanding

**MPI** - Master Patient Index

**PII** – personal identifiable information

**PHI** – personal health information

**PRA** – Paperwork Reduction Act

**RMS** – Record Management System

**SA/SUD** – Substance Use/Abuse/Dependence

**SLA** – Service Level Agreement

**SOA** – Service Oriented Architecture

**SOP** – Standard Operating Procedure

**SSL** – Secure Sockets Layer

**SWOB** – an acronym for the four components of Current data Sharing Assessment sector analysis including the strengths, “what’s in it for me” messaging, opportunities and barriers to data sharing.

**TLS** – Transport Layer Security

**VPN** – Virtual Private Network

**XML** – Extensible Markup Language

## Appendix 7.15: References

### References:

- (2016), Northshore Community Health Needs Assessment
- (2016), ServicePoint Policy Manual; August
- (2016), Summary of Mental Health Studies and Initiatives for Lake County
- (2009), HAD 150309 Factbook VFNL-ALT; March
- (2009), National Coalition for the Homeless; July
- (2010), Survey of Nonprofit Programs
- (2011), Behavioral Health in Lake County 2009-2011
- (2012), Assessing Barriers to Healthcare Access In Northern Lake County; April
- (2013), Behavioral Health Link GCAL Rolling Month Dashboard
- (2013), Community Report 2010-2012
- (2013), Mental Health Services Five Year Strategic Plan
- (2014) Lake County Mental Health Coalition LCHD-CHC Behavioral Health Planning Overview
- (2014), Enroll Lake County; November
- (2014), Improving Population Health Through Collaboration and Care Transformation HIE Community Example: 2014 Arizona Health-e Connection Annual Summit & Trade Show
- (2014), Live Well Lake County Analysis
- (2014), NASHMPD HIT and Behavioral Health Issue Paper Final; September
- (2015) Measurements, Outcomes, and Quality Assessments: A County-Informed Statewide Approach to Outcome Data Collection and Reporting; December
- (2015), A Five-Legged Stool... a Model for CIT Program Success; October
- (2015), Camden Coalition of Health Care Partners; October
- (2015), Community Report 2012-2014
- (2015), Federal Behavioral Health Quality Measures; May
- (2015), Hospital Inventory
- (2015), Jane Addams College of Social Work Mental Health Policy Report
- (2015), Lake County Health Department Community Action Plan
- (2015), Lake County Live Well Action Plan
- (2014), An Assessment of Behavioral Health Needs, Service Capacity and Projected Trends in Northern Lake County; July

## Appendix 7.15: References

- (2014), Assessment of Northern Lake County
- (2015), Psychiatric Patient Boarding Problems in the Emergency Department; June
- (2015), PRC MCHC CHNA Report, Northwestern Lake Forest Hospital
- (2016) Jail Population Report; September
- (2016) Lake County Implementation Guide- Final COCHS; December
- (2016), Arizona Health Care Cost Containment System: Justice Master Ambulatory Project
- (2016), Behavioral Health Data; October
- (2016), Community Oriented Correction Health Services; December
- (2016), CrisisNow: Transforming Services is Within Our Reach
- (2016) Crisis Now: Transforming Crisis Services in Arizona  
(<https://www.youtube.com/watch?v=ORq1MkODzQU>)
- (2016), DuPage County Community Health Center Tour; March
- (2016), Homelessness Housing Presentation to Mental Health Coalition; October
- (2016), Lake County Community Health Improvement Plan 2016-2021
- (2016), Live Well Lake County Community Health Improvement Plan
- (2016), Maki LCU Advocate Masonic Diversion Program Meeting; April
- (2017), 1995-2015 Case Filings; January
- (2017), Alliance for Human Services Presentation; March
- (2017), BHTCC Erie Waukegan Intro Presentation
- (2017), CHAS Report Updated Website
- (2017), Crisis Center Metrics: Measuring How We Help & Setting Standards; June
- (2017), Crisis Now Webinar
- (2017), Heartland Alliance Poverty Report
- (2017) Illinois HHS Medicaid Waiver Advisory Committee Discussion (Draft)
- (2017), Lake County Final Version for Presentation; March
- (2017), Lake County United Newsletter
- (2017), Maricopa County Jail Datalink Agreement; September
- (2017), North Shore University Health System Adolescent and Young Adult Inpatient; February

## Appendix 7.15: References

(2017), NorthShore University Health System- Highland Park Hospital Adolescent & Young Adult Psychiatric Center; February

(2017), Revised Track Changes Lake County Mental Health Coalition Charter, February

(2017), Presentation Behavioral Health Action Teams; February

(2017), Service Point Referral Network; June

(2017), SPRN Agreement with Jud DeLoss; May

(2017), State's Attorney Letter Requesting Permissions for HIPAA Attorney; January

(2017), The Alliance of Human Services; March

(2017), Vista Behavioral Health Program; February

BHTCC ServicePoint Training Packet- Adult Probation Client Intake Specialist

BHTCC ServicePoint Training Packet-Nicasa Incoming Referral Specialist

<https://www.azahcccs.gov/Resources/Reports/dashboard.html>

Illinois Mental Health Confidentiality Statutes

Lake County Mental Health Overview

Livewelllakecounty.org

Modernhealthcare.com

Netsmart: Policy Updated & Foundation of Value-based Care

Overcoming Barriers to Immigrant Health Care Access

Psychiatric Boarding in US EDs A Multifactorial Problem that Requires Multidisciplinary Solutions

ServicePoint Demo for Mental Health Coalition

User Policy, Responsibility Statement and Code of Ethics for Lake County's Service Point

2011 National Justice Information sharing Survey: Analysis of Results

AHCCCS's Building A Health Care System

Alameda County Health Care Services Agency, Appendix C- Alameda County Policy Matrix

Allegheny County (PA) Department of Health and Human Services, County Police Access to DHS Data, October 2016

Allegheny County (PA) Department of Human Services, Data Warehousing Flow Models, and Public Policy, November 2006

Allegheny IRC Memo, Data Sharing with Courts for IRC System, November 2014

## Appendix 7.15: References

- Appriss, Data-Driven Justice Incarceration Report, Identifying Super Utilizers with Incarceration and Prescription Monitoring Data, July 2016
- Arizona State Medicaid Health Information Technology Plan
- Bexar County (TX) Mental Health Consortium findings
- Bexar County (TX), Mental Health Transformation, Community Collaborative Toolkit, 2010
- Blueprint for Success: The Bexar County (TX) Model, How to Set Up a Jail Diversion Program in Your Community
- California HealthCare Foundation, Fine Print: Rules of Exchanging Behavioral Health Information in California
- Camden Coalition of Health Providers (NJ), Integrated Data: Unlocking Insights into Vulnerable Populations, October 2015
- Camden Coalition of Healthcare Providers, Using Integrated Data to Unlock Key Insights into Vulnerable Populations, 2006
- Center for Health Care Strategies, Inc., The Important of Data Sharing to Support Integration of Substance Use Treatment in California's Medi-Cal Program
- Center for Integrated Health Solutions Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers
- Centerstone of Kentucky's Living Room Proposal
- Code for America, Jail Dashboard Pilot Program, Jail Population Management Dashboard
- CSH 10<sup>th</sup> Decile Project (Los Angeles CA), September 2015
- CSH, The Economics of Super-Utilizers, Illinois Data-Driven Justice and Health Conference, December 2016
- Current Care, Rhode Island's Health Information Exchange CT HIT Advisory Council Meeting, February 2016
- Data Sharing Agreement between Camden City School District and the Camden Coalition of Health Care Providers
- Data-Driven Justice Initiative, Implementing Medication Assisted Treatment Program for Justice Involved Populations, The Middlesex Sheriff's Office Matador Program, December 2016
- Data-Driven Justice Playbook, How to Develop a System of Diversion discussion draft, December 2016
- Data-Driven Justice: Disrupting the Cycle of Incarceration, February 2017
- DDJ, Data-Driven Justice: Outcomes and Performance Metrics call notes, June 2017
- Department of Innovation and Technology (IL) IT Strategy, April 2016
- Eleventh Judicial Criminal Mental Health Project of Miami-Dade County (FL) Schwartz Program Update

## Appendix 7.15: References

Freedman Consulting, LLC, Gaining Ground: A Guide to Facilitating Technology Innovation in Human Services

Greensfelder, Data Sharing Strategies- How to Address Superutilizers within the Confines of Confidentiality, December 2016

Healthlaw.gov/California

Healthlaw.gov/illinois

Healthlaw.gov/kansas

Healthlaw.gov/kentucky

Healthlaw.gov/southdakota

Illinois Bar Association Newsletter, "Mental Health Matters", June 2015

Illinois Data-Driven Health and Justice Conference, "How Illinois is Poised for Data-Driven Health and Justice", December 2016

Illinois Foundation for Quality Health Care, Appendix 6- Confidentiality Protections in Illinois

Illinois Health and Human Services, Person 360, March 2016

Integrated Health Care Initiative, A Recommendation Report on Financing and Provider Preparation for Integrated Health Care, October 2016

Interview with Paul Galdys RII- 8/3/17

Johnson County (KS) Presentation on Data Analysis, October 2016

Justice Center The Council of State Governments, Bexar County (TX) Smart Justice, Redesigning a Local Justice System to Divert People with Mental Illnesses to Community Treatment

Divert People with Mental Illnesses to Community Treatment

Justice Center The Council of State Governments, Franklin County (OH), A County Justice and Behavioral Health System Improvement Plan, May 2015

Justice Reinvestment at the Local Level Fact Sheet, Johnson County (KS)

King County (WA) Health and Human Services Transformation Report, June 2016

Louisville Metro Government Dual Diagnosis Cross-Functional Team "Familiar Face" Process Flow

Louisville Metro Government Dual Diagnosis Cross-Functional Team 2<sup>nd</sup> Annual Report-Out, September 25, 2014

Louisville's Community Care Management Network Final Proposal for Pilot Study

Louisville's Community Care Management Network's Authorization for Multi-Party Release of Health Information

## Appendix 7.15: References

- Mecklenburg County (NC) Justice Reinvestment Initiative, Analysis of Jail Population Drivers 2008-2011, April 2012
- Mecklenburg County (NC) Mental Health and Criminal Justice Case Study, June 2015
- Mental Health and Criminal Justice Intercept Project Report (Johnson County KS), December 2010
- Mental Health and Developmental Disabilities Confidentiality Act (IL)
- Miami-Dade County's (FL) Patient Authorization Form for Disclosure of Health Information and/or Behavioral Health Information
- Montgomery County (KY) Community Health Assessment and Community Health Improvement Plan, 2016-2019
- Montgomery County (MD) Why Counties Matter Series, Issue 3, Addressing Mental Illness and Medical Conditions in County Jails, September 2015
- MOU between Camden County (NJ) Department of Police Services and the Camden Coalition of Health Care Providers
- MOU between Community Reach Center and Adams County Criminal Justice Coordinating Committee, January 2016
- MOU between the Coalition For The Homeless and the Louisville/Jefferson County Metro Government
- NORC at the University of Chicago's Case Study Report of Experiences from Washington State in Enabling Health Information Exchange
- Pima County (AZ) "Decriminalizing Mental Illness" Conference slide deck, May, 2017
- Policy Research Associates' "Decriminalizing Mental Illness" Conference slide deck, May, 2017
- Rhonda Fairbanks and James Austin, How your County Can and Should Use Data to Improve Justice System Outcomes or No Stories- Just the Facts
- RTI International, Extract More Value out of Call for Services (CFS) data, Turning CFS data into operational and strategic intelligence, June 2016
- SAMHSA's Current State of Sharing Behavioral Health Information in Health Information Exchanges
- San Francisco (CA) Department of Public Health Policy and Procedure Detail, September 2013
- Summary of Selected Federal Laws and Regulation Addressing Confidentiality, Privacy and Security (hhs.gov)
- The University of Chicago's Center for Data Science and Public Policy, Redirecting People with Complex Conditions to Effective Care, October 2016
- The University of Chicago's Center for Data Science and Public Policy, Preparing for Collaborative Data Driven Projects, December 2016
- University of Illinois Hospital and Health Sciences System, Healthcare Super-Utilizers

## Appendix 7.15: References

USDHHS OCR Privacy Brief, Summary of the HIPAA Privacy Rule

USDHHS Office for Civil Rights, Permitted Uses and Disclosures: Exchange for Treatment 45 Code of Federal Regulations 164.506(c)(2)