

BEHAVIORAL HEALTH ENGAGEMENT INTERIM REPORT

PREPARED FOR THE
HEALTH INFORMATION TECHNOLOGY ADVISORY COUNCIL

MARCH 2023

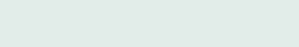


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Introduction and Background

In accordance with [Connecticut General Statute \(CGS\) 17b-59a](#), the [Office of Health Strategy](#) (OHS) is tasked with implementing and periodically revising a five-year Statewide Health Information Technology Plan (the Plan) for Connecticut. The [Health Information Technology Advisory Council](#) (HITAC) is charged with advising the Executive Director of OHS and the state's Health Information Technology Officer (HITO) on health information exchange (HIE) activities and other health IT projects. In consultation with HITAC, the Plan, which contains six key focus areas, was submitted to the legislature in February 2022. This preliminary report is submitted to HITAC to provide the status and progress on *Focus Area 4* from that Plan, *Support Behavioral Health Providers with the Adoption of EHR and HIE Services*, more specifically:

- What has been learned thus far from behavioral health providers in listening sessions
- The immediate actions OHS has taken in response to feedback and input
- OHS plans for next steps

Statewide Health Information Technology Plan Development

The Plan was developed over the course of 2021 beginning with extensive engagement of Connecticut stakeholders to gain understanding of the spectrum of readiness for, availability of, and use of health IT and HIE services by Connecticut healthcare and social services organizations, state and local agencies, and consumers. More than 1,200 individuals and organizations were engaged through webinars, focus groups, surveys, and interviews, resulting in an Environmental Scan and Draft Recommendations Report presented to HITAC and OHS in June 2021. Stakeholders were invited to provide feedback during the summer of 2021 and those insights were incorporated into the Plan. Behavioral health providers participated in those engagements, including approximately 380 behavioral health providers and organizations from five regions across the state who responded to a 65-question survey covering a broad range of health IT topics. Respondents were comprised of approximately 50% clinical providers with the remaining respondents being executive, management, and administrative staff, including those working in technology.

Behavioral Health Provider Engagement

Through a strategic planning process following the submission of the Plan, HITAC identified key priorities to initiate in 2022. The development of an educational campaign to support behavioral health providers with adoption of EHR and HIE services was identified as the top priority.

A meaningful education campaign for behavioral health providers about the benefits of using EHR technology and HIE services requires a strong understanding of the current experience of practicing professionals in behavioral health services. OHS recognized this, and during the first

half of 2022, conducted background research to organize an appropriate process for this initiative.

Using data from the Connecticut Department of Public Health licensing division on the types and number of licensed behavioral health providers in Connecticut, OHS developed categories of provider types for prioritized outreach and developed an engagement plan with the following initial objectives:

- Conduct information and listening sessions with behavioral health providers, organizations, and associations focusing on the use of information technology and HIE services, while maintaining confidentiality, to provide coordinated, holistic care.
- Evaluate financial incentive programs for Medicaid-focused behavioral health providers; work with the state employee and commercial health plans for identifying opportunities to include incentive payments in value-based contracts for participating in Connie's HIE services.
- Conduct an analysis of cloud-hosted behavioral health EHR and care coordination technology solutions and conduct a cost/benefit analysis to determine the better option for the state, provider incentive payments or access to a state hosted system or systems.
- Evaluate, plan, and develop a technical assistance and training program for behavioral health providers.

Information and Listening Sessions

With the guidance and support of DMHAS and Connie, OHS developed a behavioral health stakeholder engagement designed to gather feedback to address any concerns by providers, whether of a general, technical, or confidential nature.

The engagement began with three information sessions hosted by OHS during fourth quarter 2022. The sessions were designed to communicate, educate, and increase awareness and understanding of Connie's function as an HIE, the benefits of health information exchange in service to better integration and coordination of services for providers and residents of Connecticut, how to connect to the HIE, and the statewide statutory mandate for provider connections

Following the information sessions, OHS in partnership with DMHAS and Connie planned and conducted listening sessions for behavioral health providers. As of the writing of this report, four listening sessions have been held to gather feedback on the following topics:

1. Interoperability – how is patient data currently shared?

2. What is working well in the current state?
3. Implications of connecting to Connie (general, technical, confidential)
4. Interoperability value proposition

These topics were chosen based on the outcome of the original stakeholder engagement to inform the Plan as described earlier in this report. During the listening sessions, providers were asked to share experiences and expectations related to these topics, as well as to provide input, share concerns, and ask any questions they have about connecting to Connie and the health information exchange, both generally and in the specific context of behavioral health records.

Some primary themes emerged across behavioral health provider specialties and settings and among other stakeholders who participated in listening sessions.

Analysis of feedback from the listening sessions resulted in an additional engagement objective to the four listed above. The fifth objective is: to develop an educational campaign for providers and patients on the benefits and risks of health information exchange, focusing on ways to protect data privacy while ensuring that healthcare providers and other members of an individual's care team have the right information at the right time to provide the best care possible.

We are committed to hearing and addressing provider concerns and responding to questions. Providers, OHS, Connie and DMHAS share joint vision and priority to provide timely, equitable access to quality care and services, and the protection of patients'/ clients' privacy.

Details of Methods

Information Sessions

Three virtual information sessions were held on October 19, October 26, and October 28, 2023. All sessions were moderated by a stakeholder engagement facilitator. Presenters included Sumit Sajnani, OHS HITO, and Jenn Searles, Executive Director, Connie. Approximately 550 behavioral health providers were invited, of which approximately 120 participated. Approximately 60 questions were documented and later analyzed for themes. The general topics included:

- OHS and the agency's role pertaining to the HIE
- Connecticut General Assembly mandate
- What it means to connect and the timeframe
- Connie achievements and roadmap
- Special considerations for Behavioral Health Providers

Listening Sessions

Four listening sessions were held on January 10, February 2, March 2, and March 3, 2023. Sessions included consultant facilitators, the HITO, OHS staff, DMHAS representatives, and Connie leadership. Sessions were by invitation-only and the distribution list was achieved through previous stakeholder engagement records, feedback from subject matter experts, and stakeholder recommendations. Approximately 40 representatives from approximately 20 organizations were engaged, including from provider associations, mental health advocacy groups, and regional behavioral health action associations. The total number of participants across the four sessions was 22.

Behavioral Health specialties and credentials represented included Psychiatry, Child Psychiatry, Child and Adolescent Counseling, Forensic Psychiatry and Psychology, Family Systems and Social Work, Adult Psychology, Professional Counseling, Marriage and Family Therapy, and Integrated Primary Care.

All sessions were highly engaging and insightful and have helped achieve initial information-gathering objectives.

(See appendix for lists of invited organizations and participants).

Feedback Evaluation, Assessment and Action Plan Methodology

OHS is utilizing combined prior input from 2021, 2022 and recent 2023 engagement to develop plans for supporting the success of behavioral health providers in the execution of Focus Area 4 of the Plan. Initial findings are in concert with information collected through the environmental scan process for development of the Plan. By reinforcing privacy protections and providing support for behavioral health providers with the adoption of EHR and HIE the value of integrated and coordinated services and care will be realized.

Themes from the behavioral health stakeholder engagement

Through the engagement described above, the following themes emerged:

- Patient Privacy; trust in providers and system
- The differences between behavioral health records and other health records
- Interoperability: how patient data is currently shared & accessed
- The broad diversity of behavioral health specialties
- Care coordination and the promise of collaborative data sharing

Each of these themes is described below:

Patient privacy; trust in providers and the system

Stakeholders proclaimed that patient privacy is of primary importance not only to patients, but to behavioral health providers. Participants in listening sessions focused on the concern for patient awareness of the privacy and security of their personal data and the impact on their willingness to access care, the efficacy of treatment, and on outcomes of treatment. Participants emphasized that behavioral health records contain information about sensitive conditions that can be associated with societal stigma, and patients are mindful with high expectations about the privacy protection of their records.

Participants were concerned that a large majority of their patients do not know what Connie is, or what occurs relative to health information exchange. Furthermore, it was said that some patients/clients have significant privacy concerns with individuals or entities other than their provider having knowledge that they have a condition or seek treatment, which can be a deterrent or barrier to accessing care. There is a concern that sharing patient and client experiences or knowing those experiences have been shared with others can be further traumatizing. It is ubiquitous across stakeholders that data exchange can become a potential barrier to care, resulting in behavioral health conditions going un-diagnosed or treated, with ongoing adverse impacts to individuals, the community, and society.

Differences between behavioral health records and other health records

Behavioral health record documentation may be distinguished from other types of health care provider records. For instance, behavioral health providers have not been using EHRs for as long, nor as high a percentage as other health care providers. There is also less collection, aggregation, and sharing of behavioral health records currently occurring when compared to other health care services. While a primary objective for holistic care includes promoting EHR adoption and connections to HIEs, it is also new and unfamiliar to many providers, patients, and other stakeholders. Some behavioral health providers may not assume that connectivity will improve care coordination across the delivery system. Providers acknowledge that the sharing of certain elements of the behavioral health record will support care teams, patient centered plans of care, and better care coordination and synergy, but they perceive that this could be achieved by the exchange of redacted or truncated portions of their patient records without sharing the entire behavioral health record.

Participants generally agree that behavioral health patient records differ from the way other health care practices document patient care. While all types of health records contain clinical data elements such as diagnosis and treatment codes, and progress notes, behavioral health records may also contain psychotherapy notes. While general health medical record-keeping standards and requirements are typically formatted into a clinical summary of subjective and

objective observations, assessment, and plan (SOAP notes), a problem list, medication list, and a series of entries for various other treatment interventions, diagnostic tests, and re-assessments, the behavioral health psychotherapy notes may record conversations between providers and patients. If the psychotherapy notes are not separated from the clinical records, the content within the psychotherapy notes, along with the fears associated with employers and others knowing a person has a condition or is in treatment, creates a challenge with behavioral health record sharing. When the treatment record and progress are revealed in those notes, they are the portion of the behavioral health record considered most sensitive, along with the presence of a condition.

There is also a lack of uniformity of behavioral health record practices amongst providers, determined by the size and scope of the organization. Behavioral health providers practice in an array of healthcare settings. While those practicing in large integrated systems are accustomed to data sharing amongst treatment providers, those practicing in smaller practices, particularly those in private practice, are not generally accustomed to data sharing practices using the EHR platform of a large integrated health system. In contrast, many behavioral health providers who are in private practice, document patient information and notes in a manner structured toward protecting privacy, and many behavioral health providers do not have any history of data exchange. These differences require specific outreach activities to support the various behavioral health provider types in connecting to and participating in data sharing with the HIE.

Interoperability: how patient data is currently shared & accessed

Participants described various scenarios for sharing patient data with other parts of the system of care, and methods for accessing information about their patients housed in other systems. Wide variation was described depending on the size of the organization, whether it is affiliated with an integrated hospital and health system, and the specific communities they serve and work in, as well as the setting for the care (school, residential treatment facility, outpatient clinic, etc.). With the larger systems, all practices and specialties are using the same EHR system, or are connected through secure messaging to the EHR, and sharing patient information with others who have a treatment relationship with the patient is relatively simple.

In smaller practices, independent and solo practices, and for those practices not using an EHR, paper-Release of Information forms are used to consent to sharing of private health information, with faxes and phone calls confirming the information reside as the normal practice. There is a substantial amount of electronic referral occurring, usually via secure email. When seeking information about their patients from another provider, participants in the listening sessions described first talking to the patient about the information they are seeking, getting the release of information signed and sent to the other provider, and receiving information back via fax, conversation, or email. They explained that not all Release of Information forms are equal, as

there is no statewide standard form. In addition, not all providers honor the signed Release of Information forms, and many times behavioral health providers must make several follow up phone calls to obtain what they need. Most of the listening session participants also noted that when they are unable to obtain information from other providers, frequently the problem is inconsistent practices among providers about which HIPAA disclosures are allowed, and which are not.

It was noted by several participants of the listening sessions that independent providers continue to make up a significant portion of the behavioral health delivery system. These providers are critically needed in the system, especially during the current workforce shortage, to ensure access to needed services. Adoption of EHR technology and managing connections for health information exchange are said to be financially prohibitive for some. It was noted that many independent providers do not have technology-savvy employees to set up, operate, maintain, and troubleshoot these systems like large health systems and group practices do. Some independent providers inquired about whether they could be reimbursed somehow or receive incentives for connection that would offset the cost of connection. Participants estimated about half of all behavioral health providers are working in settings where they are using an EHR to document patient information. They are not sure they understand how the requirement to connect to Connie will play out for those who are using paper records or keeping records on computer systems that are not electronic health records.

Broad diversity of behavioral health specialties

The broad range of behavioral health provider types and specialties, includes unique challenges for certain professionals, regarding privacy protections and data sharing requirements. Participants in the listening sessions asserted that different approaches are necessary where patient record sharing is concerned. For example, forensic psychology services are frequently ordered by a court or another third party and there is a question about who decides whether the information can be shared, with whom, and for what purposes. Forensic work is also comprised predominantly of evaluation and reporting, not treatment. Neuropsychology has some challenges similar to forensic work.

Similarly, for psychologists and counselors in the education settings, whether it be in primary, secondary or higher education, the privacy and sharing of these records is governed by a different legal framework than medical records. In these cases, the Family Educational Rights and Privacy Act (FERPA) applies. There is consensus among the participants that these records would need to be approached in a special way when considering documentation, consent to share, submission to HIE, who would have access to them, and for what purposes. The challenges with Marriage and Family Therapists who provide services to couples, families, and other groups of people include needs for definitions and standards regarding which person is the client that the

record would be attributed to, who has authority to give consent, and who would be named or described in the record.

(See appendix for examples of behavioral health provider types and settings).

Care coordination and the promise of collaborative data sharing

A widespread experience shared by listening session participants is that they struggle to get patient information from other providers for care coordination purposes. They are aware of the emergence of reimbursement approaches from payers that incentivize this, but they describe frustrations with cumbersome processes of faxing, phone calls, secure emails, and repeated attempts to get information from other providers. When asked about the type of data they seek from other providers that they find useful, they state discharge summaries from hospital stays and ER visits. Participants also described working in integrated health systems or large provider groups, where they are using the same EHR as most of the other providers treating their patients, as the best scenario for getting access to their patients' information, but a significant number of behavioral health providers do not practice in such settings.

Behavioral health providers see the value to patients and care outcomes when portions of behavioral health records are being shared, and they expressed the expectation that information sharing will be reciprocated by other provider types. There was also some hopefulness expressed that the state HIE initiative will result in greater ease of obtaining information on their own patients from other providers. Some participants stated this could be useful for the assessment and treatment of behavioral health conditions in a coordinated way, and in pursuit of value and improved outcomes across the delivery system.

It became clear in discussing health information exchange with the listening session participants that there is significant variation in behavioral health specialties and settings, that present unique perspectives towards the data sharing practices of behavioral health providers. In addition to HIPPA regulations that apply to health records in other settings, there may be additional federal and state regulations governing specific licenses and specialties within the behavioral health provider setting. Listening session participants inquired about these variations with compliance and what specific data elements are required to be submitted based on these unique settings and specialties.

Other preliminary themes

The professional associations representing behavioral health providers report there is not comprehensive awareness among their members about Connie or the requirement to connect. The association staff also state that of their members who are aware of the mandate, most do not know what compliance with the mandate entails, with are confused about the requirements to share specific data, how to connect and share data, whether they will be required to use an

EHR, and among other inquiries. There are also questions about populations of patients subject to the mandate, such as veterans, members of federally recognized tribes, and patients receiving services in Connecticut who do not reside in-state.

Additional stakeholder feedback

What is currently working well

Responses to questions on the topic of what is working well varied in style and wording, but were delivered with a similar concern across the majority of listening session participants. Providers have developed tools and relationships across the healthcare ecosystem in the communities they serve. Whether or not they have adopted EHR technology, connected to Connie, or are currently sharing data with other providers, all participants in the listening sessions offered similar thoughts on their commitment to ensure their patients are informed about what is being done to safeguard their data privacy. There is a very strong allegiance among all types of behavioral health providers regarding the protection of their patients' and clients' privacy, and they feel a duty to provide clear communication about where patient data is stored, where it is being sent, who will have access to it and for what purpose; and they want their patients to have control over what can and cannot be shared.

The value proposition for interoperability and exchange

Participants in the listening sessions have expressed both skepticism and hope, that behavioral health provider participation in health information exchange through Connie will support provider collaboration, care coordination, and promote virtual care teams that work together in more person-centered care models. Participants said they would look forward to consistently getting timely information about their patients' admissions and discharges from hospital stays and ER visits. They want to be part of the discharge planning so that they can participate in necessary support and follow up care.

Participants in listening session discussions consistently reported that they are not sure they or their patients have enough awareness or knowledge of the mandate to connect to or of health information exchange in general. Nor to hold a position on whether this requirement is a good thing or not. They suggested that much more outreach, communication, training, and posted information needs to be made available.

When asked about the ideal future state for health information exchange of behavioral health data, participants agree that it begins with privacy for patients, patient consent, and granular or segmented data structure. They want patients to have control over what data is shared, who

gets it, why they need it, and how they can opt-in or opt-out, or be partially-in with a portion of their data for certain providers. Once that is available, the participants want information to be easy for them to access quickly when they need it, but housed safely and securely.

A small number of participants are not convinced of the value to care coordination and integration, even with appropriate consent and security. They are certain that not all patient data should be shared, and perhaps that none of the behavioral health data should be shared.

In addition to the inquiries collected through the listening sessions, OHS is in receipt of letters by provider associations and an interdisciplinary group requesting legislative modifications, such as a delay in the deadline for behavioral health providers to connect with Connie, and seeking answers to questions similar to those shared during listening sessions.

Stigma associated with behavioral health treatment and unique privacy needs

There is a high degree of consensus among listening session participants, across all specialties and communities, that behavioral health record sharing and information exchange raises significant privacy concerns for their patients, and should require additional protections than what is needed for sharing information about other health conditions. There remains significant societal stigma associated with mental illness and substance use disorder, and there is concern that broad expectations for data exchange will prevent some individuals to avoid from seeking treatment. Participants shared that patients have concerns about being traumatized by others' knowledge of their condition and stigmatized or discriminated against, at school, in their workplace, or elsewhere. Some patients see private pay providers when they have health insurance or employee assistance programs available to them to avoid the sharing of information beyond their provider.

Providers communicated that they and their patients have a strong preference for a policy framework, an approach to consent permissions, and data sharing requirements that would allow for data in the records to be segmented, or parsed out. Preferably, in such a way that a patient would not simply opt-out of their data being submitted to Connie, or have all their data submitted to Connie, but would have the ability to determine what portions of their records would be in the HIE, and specify what types of providers or other entities would access it. For example, they proposed that a patient would provide consent for their data to be shared with Connie, but not the therapy notes, and that their depression is something they want their PCP to be aware of, but their dentist does not have a need to know about their childhood sexual trauma. Behavioral health providers would like more clarity on how patients opt-out of having their data shared with Connie.

Privileged Information

Some stakeholders have requested additional guidance regarding the definition of “sensitive health information” in context of behavioral health providers. There is no legal definition for this term. OHS considers all healthcare information to be privileged information protected by various federal and state laws.

Aside from 42 CFR Part 2 which describes specially protected health information for certain conditions, there is no federal or national definition for sensitive health information. All healthcare records are to be kept confidential other than HIPAA allowed disclosures, or with patient’s specific written consent.

Connie has developed their own definition for *sensitive health information* which is excerpted here:

Definition of Sensitive Health Information from Connie website

“In Connecticut, certain types of substance use disorder (SUD) treatment, mental health, and HIV/AIDS information have additional protections. Connie refers to health information with enhanced protections under state law as “sensitive information.” Before sensitive information is sent to Connie to be shared through the HIE, state and federal laws may require patients to provide affirmative consent. Typically, affirmative consent occurs at the provider’s office with the patient. It allows the provider to share sensitive information with the patient’s care team that contains important clinical context for patient care coordination. Nevertheless, the typical consent process can be challenging in providing whole-person care for patients with diagnoses that include sensitive information.”

As there is no legal definition for this term, OHS considers all healthcare information to be privileged information protected by various federal and state laws, and it is expected that all data exchanged with the state HIE will be shared with the HIE in accordance with the applicable federal and state health data privacy laws.

Immediate Actions & Response

The sessions confirm what the state has learned in prior stakeholder engagements about what the common issues are for behavioral health providers regarding health information exchange. OHS, DMHAS and Connie are appreciative of the time committed and thought invested by behavioral health representatives throughout these engagements. It is clear that participating

providers care about a system working for the benefit of their patients. Collaborative dialogues are progressing and OHS looks forward to further engagement.

OHS has published an evolving FAQ section on the agency website to respond to some of the inquiries made during listening sessions. Additional questions are expected as more behavioral health providers learn about Connie and the health information exchange. The FAQ section on the OHS website will be updated periodically to provide answers to the most common inquiries and assist the reader in understanding how the state designated HIE operates and the requirements for connecting to Connie.

The themes of cost, confidentiality, privacy, and security, as well as questions and skepticism about the value this requirement will bring behavioral health providers and their patients are familiar concerns for OHS. A great deal of thought and research has been put into these issues since the finalization of the Health IT Plan and the legislative requirement for provider connections to the HIE. The current engagement with behavioral health providers, and the concerns and questions raised during the listening sessions are being used to inform planning and a roadmap for further evaluation, policy development, and implementation. The campaign to connect to Connie and receive training about submitting patient data is aligned with and compliant with all federal and state privacy and security laws governing patient data.

OHS, DMHAS and Connie continue to plan and execute new ways to disseminate information on the processes, and make sure all behavioral health providers understand that they must check with their specific licensure regulations to determine specialized state and federal laws, and privacy rules, along with HIPAA, that may determine what type of information may be shared, and to educate their patients about the choice to opt-out of having their data shared through Connie. The listening sessions garnered various types of specific and detailed questions from participants about the opt-out process and how it is being communicated to the public and to behavioral health providers.

OHS is confident that some of the concerns behavioral health providers have about connecting to Connie are based on misinformation or assumptions about the requirement, and that many providers in the behavioral health realm have not seen or reviewed enough information to determine if HIE services through Connie will add value to their practice or to their clients. Connie leadership desires to put patients in control of their data. All health care data, including behavior health data is privileged information protected by HIPAA and may be shared for treatment purposes. All behavior health providers must also check with their specific licensure regulations to determine additional federal and state laws, and specialized privacy rules beyond HIPAA, that may govern their specific license, certification, and/or specialty.

As currently practiced, prior to completing the health information exchange connection with Connie, behavioral health providers must inform their patients of their participation in Connie, not unlike the information exchange during the initial point of care, when patients are informed

about the various ways their information may be shared under HIPAA, for treatment purposes. The practice of sharing patient data for treatment purposes is not a new concept and it is assumed that all providers have had privacy and consent policies even prior to state HIE requirement taking effect. Patient communication about the state HIE is important.

Roadmap for Further Evaluation, Input, & Validation

As of the writing of this preliminary report, additional engagement is being planned both for sharing information and collecting more input, and for raising awareness of Connie and the benefits of health information exchange to behavioral health providers and their patients. Additional input and validation towards the input provided thus far, may include further dialogue with providers and constituents, focus groups, key informant interviews, and an electronic survey. Communications and information may be disseminated through associations, legislators, and advocacy groups. Connie is planning a marketing and awareness campaign that will be delivered in multiple modalities to help both providers and consumers increase their understanding and awareness of what an HIE is and what Connie does, as well as how data is protected and secured. Workplans are being developed to evaluate incentive programs and technical assistance to providers who face costs or technical expertise as barriers to connection and sharing data. OHS will continue engaging behavioral health providers and their associations as they move along toward the process to connect with Connie.

Appendix

Listening Session Invitees and Participants

Organizations Invited

Connecticut Academy of Family Physicians
Connecticut Chapter of American Academy of Pediatrics
Connecticut Psychiatric Society
Connecticut Psychological Association
National Association of Social Workers - Connecticut Chapter
Connecticut State Medical Society
Connecticut Council of Child and Adolescent Psychiatry
Connecticut Association for Marriage and Family Therapy
Connecticut Counseling Association
Connecticut Association of School Psychologists
Advocacy and Education for Addiction-Focused Professionals
Connecticut Certification Board, Inc.
Connecticut Advanced Practice Registered Nurse Society
Mental Health Connecticut
FAVOR
CT Family Support Network
Regional Behavioral Health Action Organization – Region 1 – The Hub
Regional Behavioral Health Action Organization – Region 2 – Alliance for Prevention Wellness – BH Care
Regional Behavioral Health Action Organization – Region 3 – Southeastern Regional Action Council
Regional Behavioral Health Action Organization – Region 4 – Amplify
Regional Behavioral Health Action Organization – Region 5 – Western CT Coalition

Organizations Participated

Connecticut Association for Marriage and Family Therapy (Wolcott, Hartford, and Farmington)
Connecticut Psychological Association
Connecticut Psychological Association, Forensic Division
National Association of Social Workers – Connecticut Chapter and Ethics Committee
Connecticut College
Connecticut Counseling Association

Central Connecticut State University Department of Counselor Education and Family Therapy
Favor, Inc Region 2 (Statewide non-profit empowering and connecting families to services, advocacy)

Southwestern Regional Action Council (SRAC), a Regional Behavioral Health Action Organization (RBHAO)

FAVOR, Inc. Region 3 (Statewide non-profit empowering and connecting families to services, advocacy)

Connecticut Council for Child and Adolescent Psychiatry

Institute of Living Child and Adolescent High Intensity Treatment Program

Yale Medicine, Department of Psychiatry

AMPLIFY, a Regional Behavioral Health Action Organization

Examples of Behavioral Health Providers Types and Settings

Examples
Psychologists
Licensed Clinical Social Workers
Licensed Professional Counselors
Marriage and Family Therapists
Licensed and/or Certified Alcohol and Drug Counselors
Victim and Domestic Violence Counselors / Sexual Assault Counselors
Advanced Practice Registered Nurses
Psychiatrists (MD)
School-Based Health Centers
University Health Centers
Federally Qualified Health Centers
Solo and small practices with less than 5 providers
Mid-size practices with 10 to 20 providers, likely-to-adopt-EHR
Mid-size practices with 10 to 20 providers, not-likely-to-adopt-EHR provider practices
Large practices with 20+ providers or integrated health systems with an existing EHR
Dominant or leading telehealth providers