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>> Report on Health Information Technology and Health Information Exchange Among Oregon's Behavioral Health Agencies



Oregon
Health
Authority

HEALTH POLICY AND ANALYTICS DIVISION
Office of Health Information Technology

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Executive summary

Behavioral health system improvement is a priority for Oregon

Oregon is in the process of transforming its health care system in pursuit of the Institute of Healthcare Improvement's Triple Aim: better health, better care and lower costs. Inherent in these goals is the need for increased coordination of care between physical, behavioral and dental health care. With the establishment of Oregon's coordinated care organizations came a focus and investment in such a model, in which health information technology (HIT) plays a critical role. The purpose of this report is to describe the current context for and state of HIT and health information exchange (HIE) in Oregon's behavioral health system.

The Oregon Health Authority (OHA) is committed to improving Oregon's behavioral health system. The Oregon Health Policy Board (OHPB; the policy and oversight board of OHA) has identified behavioral health system improvements as a focus area of its Action Plan for Health refresh. The board has also charged the Health Information Technology Oversight Council (HITOC) to include behavioral health as a focus area in the use of HIT and health information exchange (HIE) for improved care coordination.

In 2017, the importance of HIT and HIE for behavioral health system transformation was underscored in the Behavioral Health Collaborative's (BHC's) recommendations. Convened by OHA and composed of a diverse group of more than 50 behavioral health stakeholders across Oregon, the BHC put forth a set of recommendations to guide the transformation of Oregon's behavioral health system into a coordinated care model that will integrate behavioral health with physical and oral health. The BHC recognized that such a system requires HIT and HIE to provide access to relevant patient information across the spectrum of care. Accordingly, one of four overarching BHC recommendations includes action steps to increase HIT/HIE for behavioral health.

Environmental scan of HIT/HIE among Oregon's behavioral health agencies

Until now, little was known about the current status of HIT and HIE within Oregon's behavioral health system. OHA conducted an environmental scan of HIT/HIE in Oregon's BH agencies (BH HIT/HIE Scan) to better understand HIT and HIE adoption, use, needs and challenges that behavioral health agencies experience and to inform policies and strategies around these efforts. The scan included an online survey and a series of in-depth interviews.

OHA sent online surveys to all 275 Oregon behavioral health agencies administering at least one licensed behavioral health program. These agencies administer 874 total OHA-licensed behavioral health programs. Approximately half of the agencies responded to the survey, representing 60 percent of all Oregon licensed programs. OHA also conducted follow-up in-depth interviews with 12 agencies, which represented a broad range of agency characteristics.

Key results and conclusions of OHA's Behavioral Health HIT/HIE Scan

Key result 1: Most behavioral health agencies are investing in HIT. However, the systems often do not adequately support the full spectrum of behavioral health's HIT/HIE needs.

Conclusion 1: Most behavioral health agencies could benefit from additional HIT support.

Key result 2: Most behavioral health agencies need to exchange information with other entities; however, few are doing so using modern electronic methods.

Conclusion 2: Behavioral health agencies need HIE opportunities, which are presently nascent and evolving.

Key result 3: In addition to resource barriers, privacy and security concerns are a top barrier to electronic information exchange.

Conclusion 3: Behavioral health stakeholders need more support and clarity about privacy and security of health information.

Key result 4: Data analytic tools and capabilities are necessary for improved patient care, reporting and practice management.

Conclusion 4: Behavioral health agencies could benefit from additional resources and support for data analytics.

Current OHA HIT/HIE strategies

OHA is currently pursuing many strategies that will help improve HIT/HIE access for behavioral health stakeholders. Virtually every HIT/HIE effort in Oregon affects behavioral health stakeholders, because they are critical members of the coordinated care team. Some of these efforts include:

- The **Medicaid EHR Incentive Program** provides financial incentives for EHR adoption and use to some behavioral health providers.
- The **HIE Onboarding Program** will help priority Medicaid behavioral health providers (among others) make the initial connection (onboarding) to a community-

based HIE that provides meaningful HIE opportunities and plays a vital role for Medicaid in communities.

- **PreManage**, a tool that provides information about emergency department and inpatient admissions to non-hospital care providers, including admissions that relate to behavioral health needs. Many behavioral health providers are currently using PreManage to ensure better care coordination.

OHA will continue to pursue these current HIT/HIE strategies while also further considering the findings and recommendations identified in this report. OHA looks forward to continuing behavioral health stakeholder and Tribal Government involvement in this work that is critical to the transformation of Oregon's behavioral health system.

Behavioral Health HIT/HIE Scan

Background

Integrating and coordinating care between physical, behavioral and dental providers is critical to Oregon's health system transformation. HIT and HIE are essential components of a more cohesive system that facilitate information sharing between treating providers.

The Oregon Health Authority (OHA) is committed to improving Oregon's behavioral health system. The Oregon Health Policy Board (OHPB; the policy and oversight board of OHA) has identified behavioral health system improvements as a focus area of its [Action Plan for Health refresh](#). The board has also charged the Health Information Technology Oversight Council (HITOC) to include behavioral health as a focus area in the use of HIT and health information exchange (HIE) for improved care coordination.

The recommendations of the Behavioral Health Collaborative (BHC) in 2017 underscored the importance of HIT and HIE for behavioral health system transformation. Convened by OHA and composed of a diverse group of more than 50 behavioral health stakeholders across Oregon, the BHC put forth a set of recommendations to guide Oregon's behavioral health system's transformation into a coordinated care model that will integrate behavioral health with physical and oral health. The BHC recognized that such a system requires HIT and HIE to provide access to relevant patient information across the spectrum of care. Accordingly, one of four overarching BHC recommendations includes action steps to increase HIT/HIE for behavioral health.

OHA has prioritized the modernization of its behavioral health system, which includes strengthening the use of HIT. As such, several strategies are currently underway to support the various technology-based aspects of the behavioral health care system. They include required reporting and metrics; the exchange of priority, relevant patient information to improve care and outcomes; and data for new payment models. To accurately define the roadmap to improvement and to meaningfully inform policy and strategies, it is crucial to know the current status of the behavioral health HIT/HIE environment.

To that end, OHA developed and administered an online survey to Oregon's licensed behavioral health agencies (that administer at least one OHA-licensed program) inquiring about HIT and HIE needs, investments, uses, challenges and priorities. OHA conducted in-depth follow-up interviews with a small, representative group of behavioral health agencies to further examine these topics and to ascertain the context and contributing factors for their various successes, challenges and ongoing needs.

The Behavioral Health HIT/HIE Scan survey and interview activities broke new ground in our understanding of the overall environment of behavioral health HIT/HIE needs. It has sparked many new questions that will help Oregon move forward in meaningfully supporting behavioral health providers' HIT/HIE needs.

Online survey

Note: All tables and graphs in this section represent information for the 133 agencies that participated in the survey.

Table 1. Demographics of agencies responding to survey

Agency size	Number of agencies	Response rate
Single program	57	44%
Two programs	28	51%
Small (3–5 programs)	25	56%
Medium (6–10 programs)	14	56%
Large (11+ programs)	9	60%
Total respondents	133	49%

Agency type	Number of agencies	Response rate
Frontier only	6	67%
Frontier, rural	2	100%
Frontier, rural, urban	1	100%
Rural only	34	47%
Rural, urban	18	49%
Urban only	72	48%
Total respondents	133	48%

Agency type	Number of programs	Response rate
Outpatient alcohol and drug	195	54%
Outpatient mental health	182	63%
Adult mental health residential	101	75%
Alcohol and drug residential	24	45%
Intensive treatment services	15	60%
Alcohol and drug correctional residential	5	45%
Total respondents	522	60%

OHA sent an explanation of the Behavioral Health HIT/HIE Scan along with a link to an online survey to all Oregon behavioral health agencies administering at least one licensed behavioral health program. The 275 agencies OHA contacted administer 874 total programs. Approximately half (49%) of the agencies responded to the survey, representing 60 percent of all licensed programs in Oregon.

Agencies that participated in the survey are a broad cross-section of Oregon behavioral health organizations. They are from all geographical regions running the gamut from urban to rural to frontier. Over half of the respondents administer just one or two programs, while others run many programs (58 total programs for the largest agency). They offer a variety of mental health and substance use disorder services to adults and youth, focusing on many different populations. Many of the respondents represent Oregon's safety net behavioral health programs—those that serve the most vulnerable Oregonians and those facing the most serious health disparities.

Responding agencies showed high engagement by thoroughly completing the survey and providing more detail than required via “other” responses; more than three-quarters of the respondents expressed interest in participating in a follow-up interview.

Limitations of the scan

Almost half of Oregon's agencies with at least one licensed behavioral health program participated in the survey. Agencies that participated in the survey may be more engaged in HIT/HIE than those that did not participate. Thus, the results described in this report reflect participants' experience but not necessarily those of the non-responding agencies that may have different experiences, challenges and needs. Further, behavioral health providers not offering a licensed program, such as private practice providers, were not in this survey's scope.

In-depth interviews

Based on information collected via survey, OHA identified a sample of 20 agencies representing various agency characteristics and invited them to participate in a follow-up phone interview. The agencies varied with respect to:

- Number of programs administered
- Geographic location(s)
- Population density of geographic location(s)
- Characteristics of population served (Native Americans and tribal, racially and ethnically diverse, justice-involved, children and youth vs. adults, etc.)
- Provision of physical health services
- EHR implementation status, EHR vendor, EHR satisfaction, and duration of EHR use Willingness to engage with HIE.

OHA completed in-depth follow-up interviews with 12 agencies. Interviewees were exceptionally engaged, eager to discuss their experiences with HIT/HIE, and often willing to spend additional time providing helpful and pertinent details about their agency’s approach to and use of information technology tools. OHA learned a great deal from these conversations, which helped deepen our understanding of the challenges and needs behavioral health agencies, providers, patients and tribal governments face. This rich contextual information supplemented the survey results and will help inform OHA’s approach to supporting the transformation of the BH system.

Behavioral Health HIT/HIE Scan results

Key result 1: Most behavioral health agencies are investing in HIT. However, the systems often do not adequately support the full spectrum of behavioral health’s HIT/HIE needs.

Behavioral health agencies have adopted and are using EHRs and/or other information management technology at relatively high rates—three-quarters reported using an EHR. As noted above, it is difficult to know the overall statewide rate of EHR adoption among behavioral health agencies due to the likely over-representation of agencies in this sample with an EHR. However, the responding agencies represent 60 percent of all licensed Oregon behavioral health programs. As a result, the data show a substantial number of behavioral health providers are currently investing in HIT.

This is an impressive rate of adoption, given that the vast majority of behavioral health providers are not eligible for the Medicaid EHR Incentive Program for meaningful use of

Figure 1: Percent of behavioral health agencies currently using an EHR (N=133)

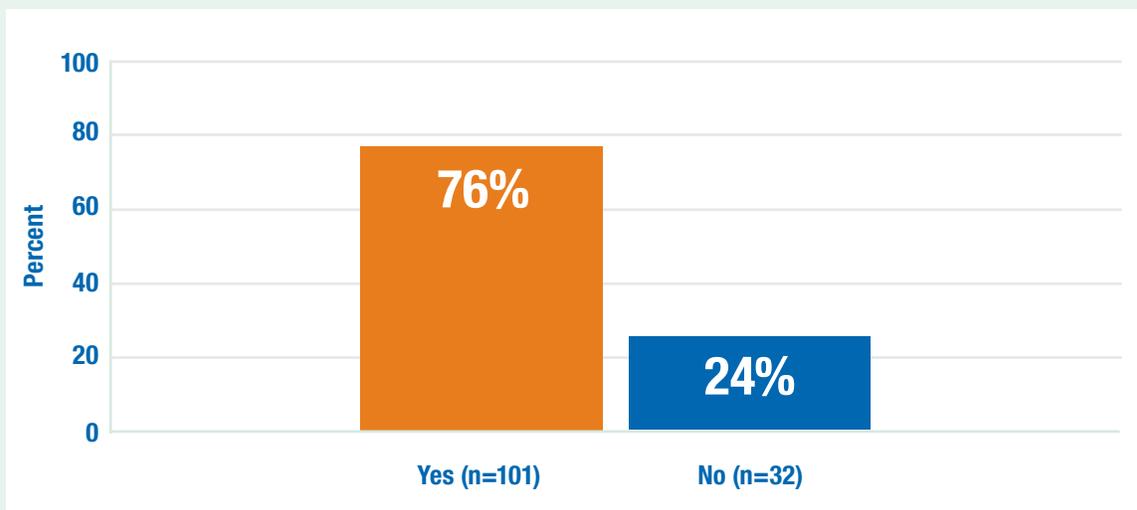


Figure 2: Percent of behavioral health agencies using other IT (N=133)

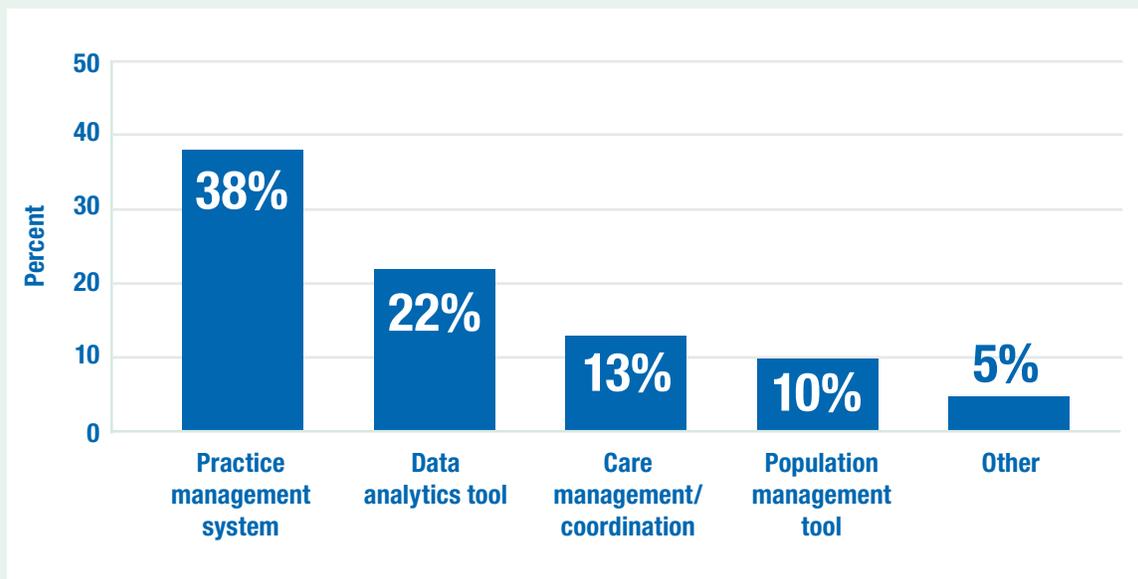


Table 2. EHR challenges for those who have an EHR

Challenge		Count	Response rate
1	Financial costs	71	70%
2	Unable to ex-change information with other systems	55	54%

certified EHR technology (CEHRT) that has been so instrumental in driving high rates of EHR adoption among Oregon’s physical health providers.* Indeed, most of the agencies that have not yet adopted an EHR reported financial costs as a barrier and 70 percent of agencies that have adopted an EHR identified financial cost as a challenge.

Although most behavioral health agencies had adopted an EHR, there was little consolidation around EHR vendor systems in use. Approximately 60 different EHR/HIT systems were indicated in the survey across the 101 agencies reporting using an EHR. Further, despite challenges, satisfaction rates were fairly high: 62% of agencies that adopted EHRs are somewhat or very satisfied with their EHR.

* Many of Oregon’s largest BH agencies and those with co-located physical health clinics have received Medicaid EHR Incentive Program incentives, which provide up to \$63,750 per eligible provider over six years. However, given that only physicians, nurse practitioners and physician assistants (in certain settings) are eligible, the majority of BH providers at an agency would not be eligible, significantly limiting the potential incentive funds available to BH agencies when compared to their physical health clinic counterparts. To date, Oregon’s Medicaid EHR Incentive Program has paid 128 behavioral health providers. In addition, 32 new behavioral health providers have attested in program year 2016. The program runs through 2021, but it is now closed to new enrollees.

In-depth interview findings

A major theme of the interviews was that EHRs provide good value, especially when they handle billing functions and help agencies better understand workload, outcomes and opportunities for improvement. All agencies expressed being fully committed to their EHR investment and showed a strong interest in increasing use of HIT to provide better care and increase efficiency. However, they also communicated barriers and challenges to greater HIT investment and use.

A consistently expressed challenge was the financial costs associated with their EHRs. In addition to the expected implementation and maintenance costs, many behavioral health agencies manage multiple grant- or contract-supported programs that necessitate regular EHR modifications as program requirements for data tracking change, increasing maintenance costs. A few agencies reported various informal efforts to manage EHR costs, such as bulk purchases with other behavioral health agencies, “cloning” another agency’s EHR instance (with vendor approval) and being an additional user for another agency’s EHR.

Behavioral health agencies offer highly diverse programs and services that require varied EHR functionality. For example, agencies offering substance use services have different EHR needs than those providing only mental health services, requiring functionality for safeguarding protected information. As another example, some agencies offer additional social service supports requiring tracking and managing different data, making it challenging to use an off-the-shelf EHR. Interviewees reported that many EHRs that offer functionalities of interest are designed for physical health entities that track different information, have different workflows and require different reporting capabilities.

Further, 31 behavioral health agencies reported they are co-located with physical health and using the same EHR. A few had co-located physical health providers but used different EHRs; most of these agencies (nine of 10) did not share information electronically across these systems.

IS YOUR EHR A SIGNIFICANT FINANCIAL BURDEN?

“ It’s a significant financial investment ... I wouldn’t call it a burden. ”

Table 3. Top EHR systems

EHR system	Number of Agencies
Credible	11
CareLogic — Qualifacts	10
Epic	8
NextGen	6
OWITS	4
OCHIN — Epic	4
myEvolv	4
Clinicians Desktop — The Echo Group	3
Centricity — GE Healthcare	3
All others	57
Total number of agencies (some reported more than one system)	110

“As much as we pay for it, plus our system support costs, I could hire another physician.”

“If you want a system to function correctly, it needs a lot of maintenance... You need somebody with expertise...”

“A lot of what we do is customizing it [our ehr] to fit a square peg in a round hole.”

“Getting an EHR as comprehensive as we need is challenging ...”

Based on the survey responses, most agencies had invested in IT staff. However, approximately 30 percent had no staff but had other IT support, and 14 percent had no support. EHR adoption was particularly difficult for agencies that lack in-house IT support. One interviewee who discussed the challenges of being a clinician working with the vendor’s EHR adoption staff, said, “We [clinicians with no technical background] need IT staff who speak our language.”

Finally, behavioral health providers often cannot afford more robust EHRs, and smaller vendors may be less able/willing meet customization needs at an affordable cost. One agency reported that their vendor required a \$1,000 payment, on top of an hourly fee, to merely provide a quote for needed customizations to meet grant requirements.

Result 1a. Nearly one-quarter of agencies do not have an EHR; they tend to be smaller and face greater resource barriers.

Of the 31 agencies that reported not yet having adopted an EHR, 18 (58%) have plans to implement an EHR or are in the process of doing so. The remaining 13 (42%) have no plans to implement an EHR; these are all small agencies (one to five programs) that indicated their size did not justify the investment.

Financial cost was the most commonly cited barrier to EHR implementation, experienced by three-quarters of respondents with no EHR. Other barriers included small agency size (felt investment was not worth it), lack of staff support, and lack of resources and technical infrastructure.

More than half of respondents without an EHR cited increased information exchange with other clinicians as a potential benefit. However, half of respondents with an EHR reported being unable to exchange information with other systems as a top challenge.

Figure 3: For agencies without an EHR: stage of EHR adoption (N=32)

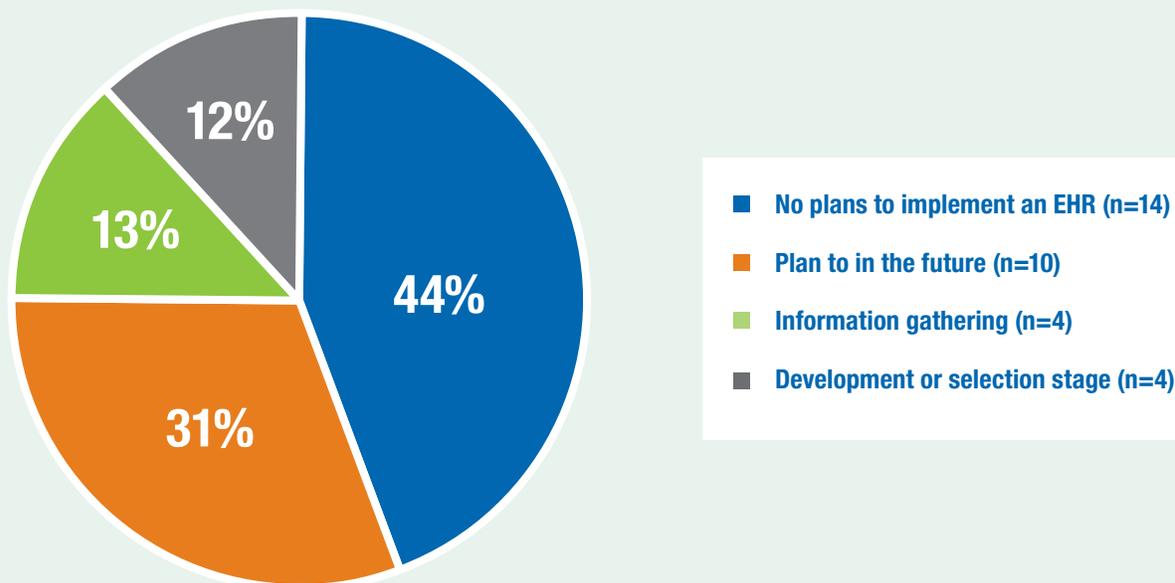


Table 3. EHR barriers for agencies that do not have an EHR (N=32)

Barriers to EHR adoption		Count	Response rate
1	Financial cost	25	78%
2	Agency size is too small to justify the investment	21	66%
3	Lack of staff resources	15	48%
4	Lack of technical infra-structure	15	48%

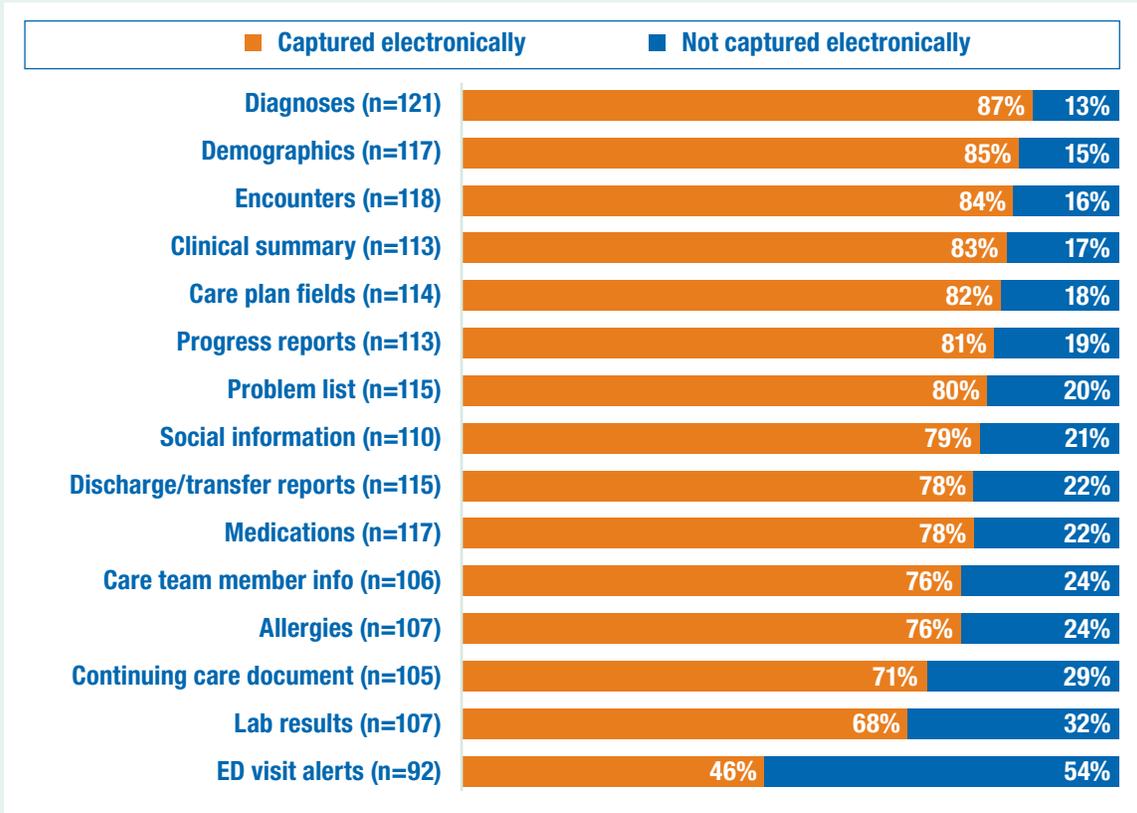
Result 1b. Behavioral health agencies are electronically capturing a broad array of information critical to care coordination and integrated care. However, many of the systems are unable to capture all needed data and/or lack critical capabilities for processing and meaningfully using stored information.

Most agencies are capturing diagnoses, demographics, encounters, problem lists, social information and many other priority data fields within their EHR or other information technology system. Thus, behavioral health organizations are capturing data that may be helpful to physical and/or oral health partners.

In-depth interview findings

Interviewees reported they are capturing a wide array of basic information about patients. Much of the information is like what physical health providers capture. Behavioral health agencies that provide a broad range of services experience challenges with their system's

Figure 4: Types of data captured electronically (N=133)



Note: n's (e.g., n=121) represent the number of respondents who provided a response.

capability to capture all relevant (program-specific) information. Many interviewees discussed EHR limitations related to using stored information for reporting purposes. In addition, interviewees noted their practice management needs (e.g., the need to track administrative issues such as caseload size and efficiency, show-up rates and program-specific data elements required for grant or contract reporting) are not being sufficiently met by their IT systems.

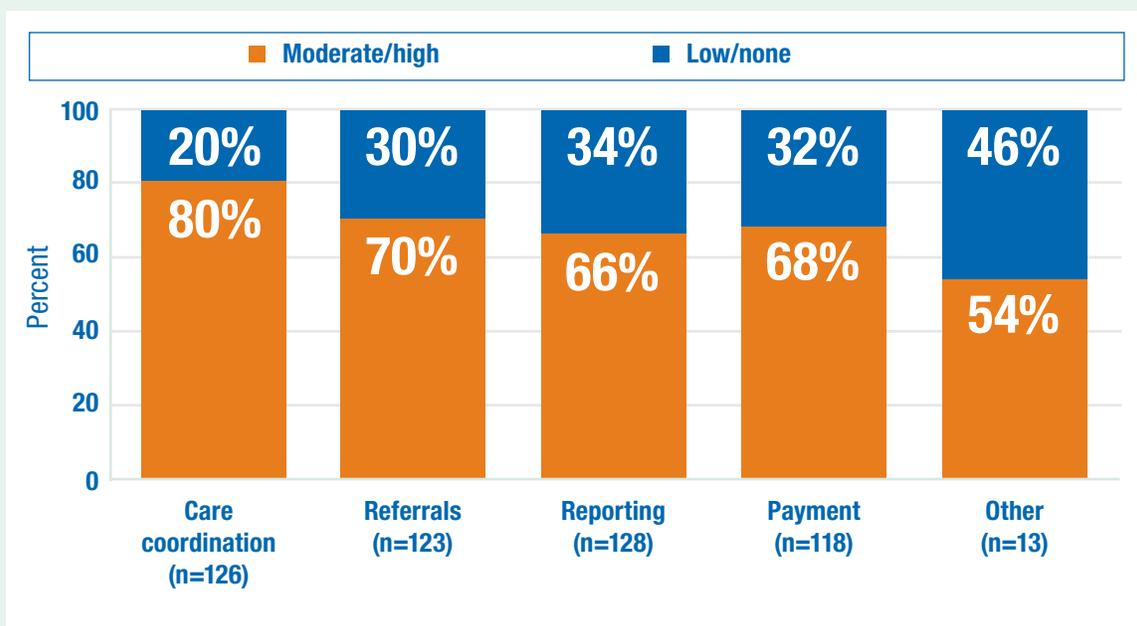
Conclusion 1: Most behavioral health agencies could benefit from additional HIT support.

- **Need 1a:** Robust HIT tools available in the marketplace that serve behavioral health specific needs
- **Need 1b:** Financial support and technical assistance for EHR adoption, implementation, maintenance or upgrade
- **Need 1c:** Opportunities for collaboration and shared learning around EHR adoption.

Key result 2: Most behavioral health agencies need to exchange information with other entities; however, few are doing so using modern electronic methods.

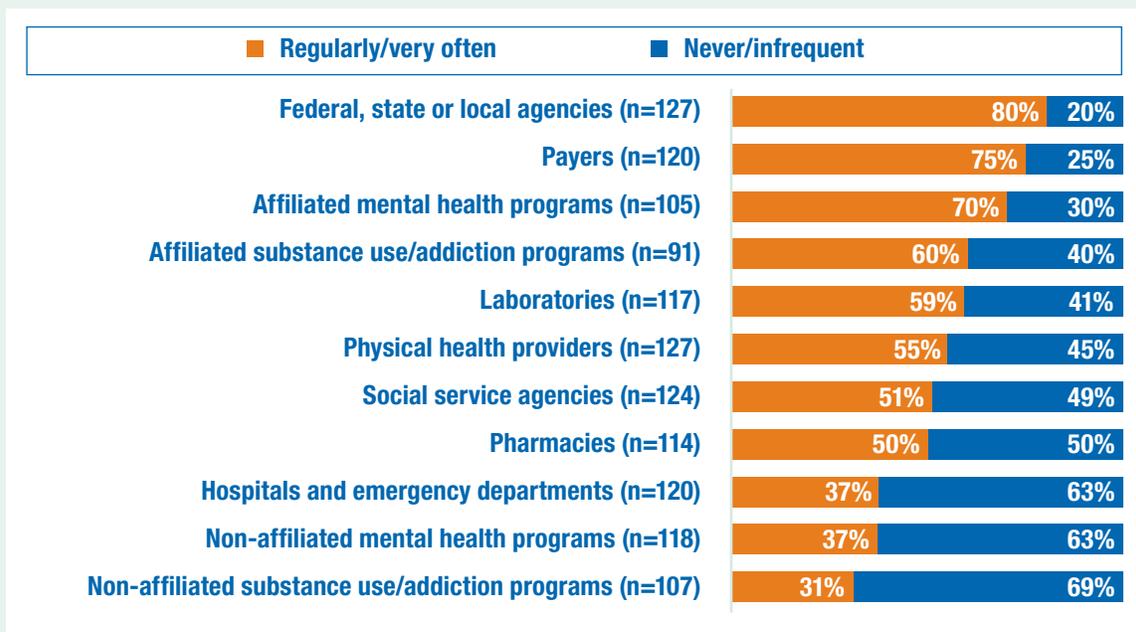
Respondents expressed a strong need to exchange data with other organizations for care coordination, referrals, reporting and payment of services. In particular, agencies identified care coordination as a primary driver of information exchange; this may relate to the frequently complex care needs of individuals seeking behavioral health care. Behavioral health providers often need to both share and access information about their clients with other entity types.

Figure 5: Agency data sharing need by purpose (N=133)



Note: n's (e.g., n=126) represent the number of respondents who provided a response.

Figure 6: Information sharing needs with trading partners (N=133)

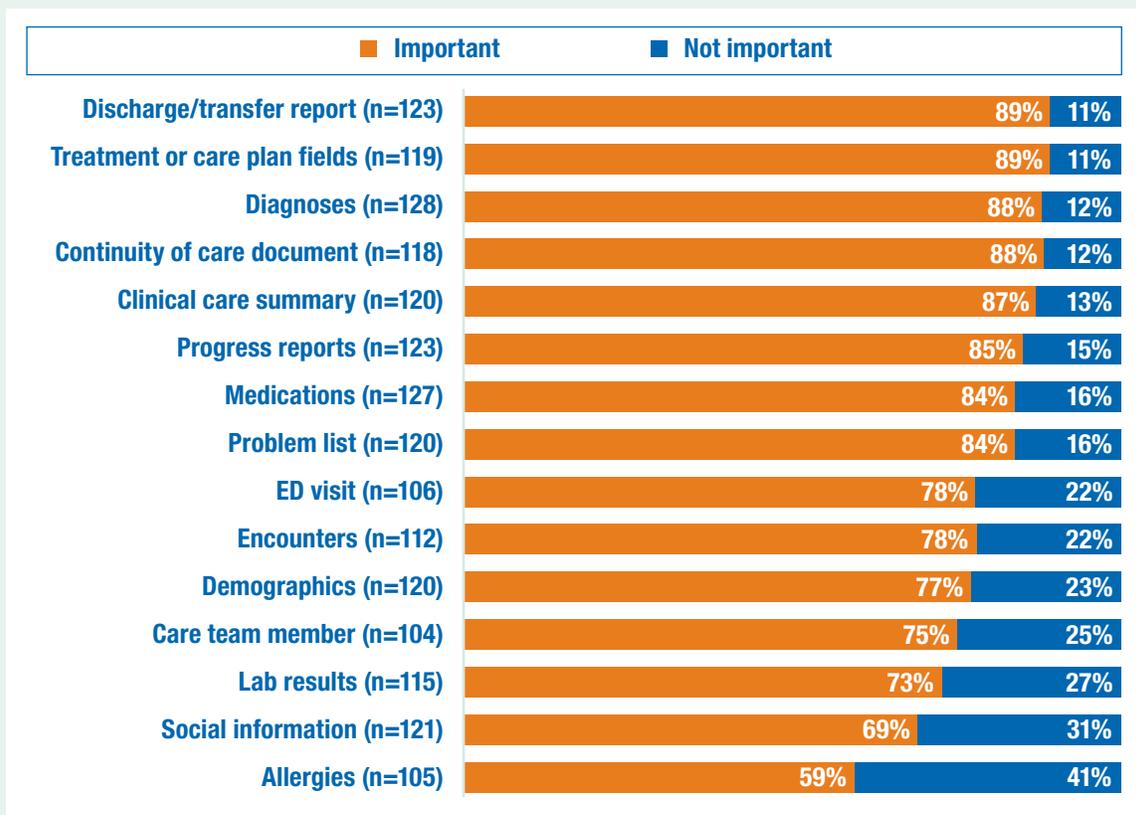


Note: n's (e.g., n=127) represent the number of respondents who provided a response.

Result 2a. Behavioral health agencies reported that it is important to be able to share all types of patient information.

Agencies reported interest in a wide range of data; at least 60 percent of respondents reported that each core data element was important to share. Most of the commonly available information is relevant to behavioral health care and contributes to a more complete picture of the individual and that person’s needs. Many behavioral health care recipients have complex needs and long histories of various treatments that can be challenging to recall. The more relevant information can be accessed at the point-of-care, the more likely the patient will receive the needed care.

Figure 7: Data important to share (N=133)



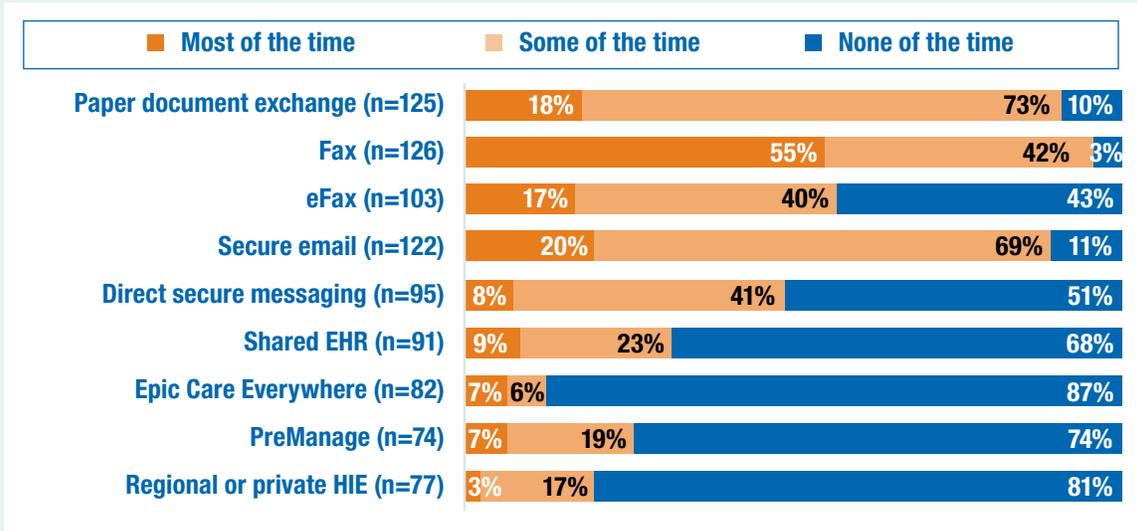
Note: n's (e.g., n=123) represent the number of respondents who provided a response.

Result 2b. Behavioral health agencies are currently exchanging Information mostly via fax, paper, secure email, efax and Direct secure messaging. How they exchange information is influenced by the HIE capabilities of information trading partners.

Behavioral health agencies are exchanging information with various entities including hospitals, laboratories, pharmacies, affiliated and non-affiliated behavioral health providers, as well as payers and government agencies. Most of this information sharing is occurring using more basic exchange methods, which limits the extent to which information is integrated into provider workflows.

Only 19 agencies reported using PreManage, a relatively new statewide tool to access hospital event data. (See “Recommendations” section for more detail on this tool.)

Figure 8: Frequency of methods used for information exchange (N=133)



Note: n's (e.g., n=74) represent the number of respondents who provided a response.

In-depth interview findings

Every agency interviewed reported a need to exchange health data and most identified a range of at least four information trading partners (if not many more). This includes partners whose work affects the social determinants of health. All interviewees confirmed the finding that much of the information exchange is still done via fax. One said, “Our HIE is ‘faxing.’”

Another agency, with a relatively robust EHR, noted that the technical capabilities of the least technologically advanced trading partner tend to drive the exchange method.

Multiple interviewees stated that the currently necessary reliance on faxing decreases speed and efficiency. Two interviewees also raised the issue of privacy concerns caused by faxing and paper document exchange.

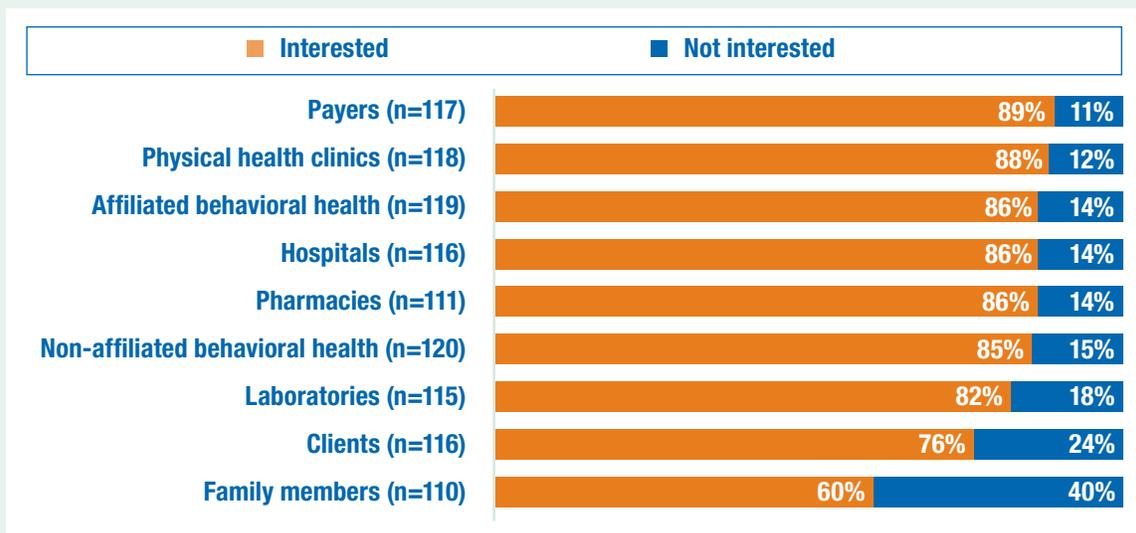
“ I’m sort of amazed that we still do as much faxing as we do today, because it’s such an old technology, but everybody asks for a fax.”

“ Paper has more opportunities [than EHRs] for breaches of privacy. Faxing is just as bad – you never know who is standing at the other end.”

Result 2c. Almost all respondents reported an interest in expanding their ability to exchange information electronically with a wide array of trading partners.

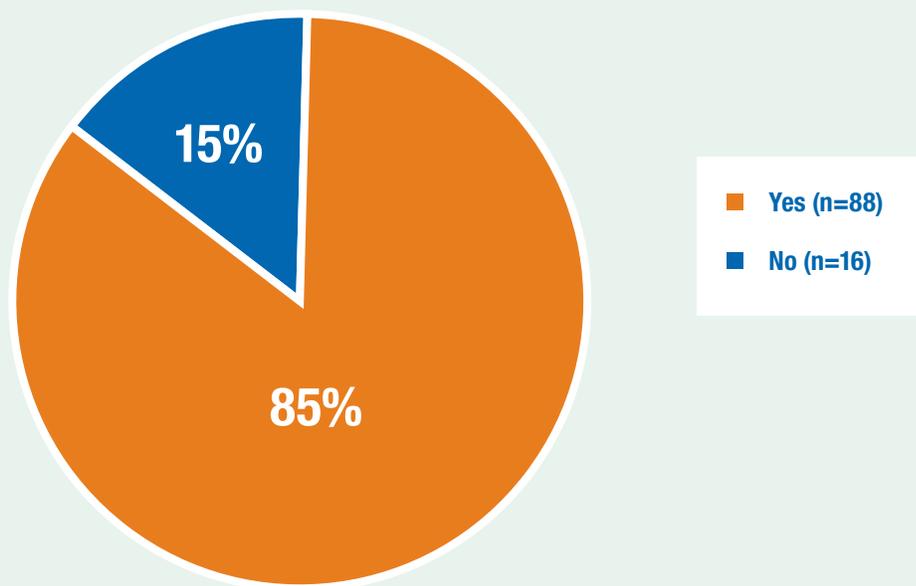
There is significant interest in exchanging information via a regional or private health information exchange (HIE); more than 80 percent of respondents reported an interest in both sharing and accessing client information via an HIE. The top concerns regarding participation in an HIE are financial cost, privacy and security concerns, limited technical resources, and liability concerns about re-disclosure of information.

Figure 9: Interest in expanding electronic exchange capabilities with other entities (N=133)



Note: n's (e.g., n=117) represent the number of respondents who provided a response.

Figure 10: Interest in sharing client info via an HIE (N=104)



Conclusion 2: Behavioral health agencies need HIE opportunities, which are nascent and evolving.

Respondents weighed in on what resources they need to remove barriers to electronically sharing and exchanging health information.

- **Need 2a:** HIE tools that can serve behavioral health specific needs. This includes the ability to exchange information with priority information trading partners, including social determinants of health partners.
- **Need 2b:** Financial support and technical assistance for HIE participation.
- **Need 2c:** Robust HIT to support participation in health information exchange.

Regional or private HIEs provide a wide array of connections and exchange services, potentially including

Core HIE services

- Community health record
- Integrated eReferrals
- Hospital/clinical event notifications
- Results/reports from lab, pathology, discharge summaries, etc.

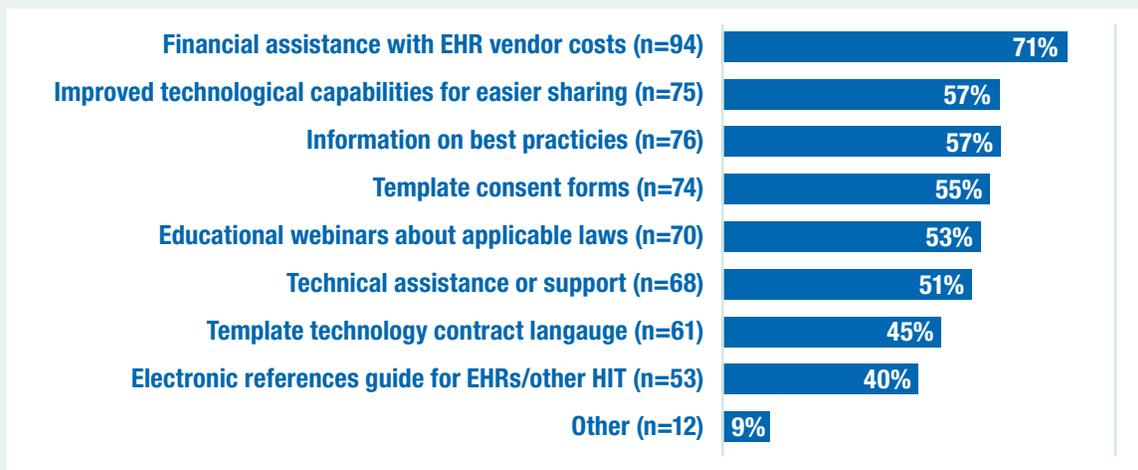
Connecting across sectors and data sources

- Physical health, dental, mental health and addictions treatment information
- Spreading into post-acute, EMS, long-term services and supports, social services hubs, corrections
- Managing consent for specially protected data and non-health data

Data for payers, value-based payment

- Source of clinical data for payers
- Some adding claims data for providers.

Figure 11: Resources needed to help remove information sharing barriers (N=133)



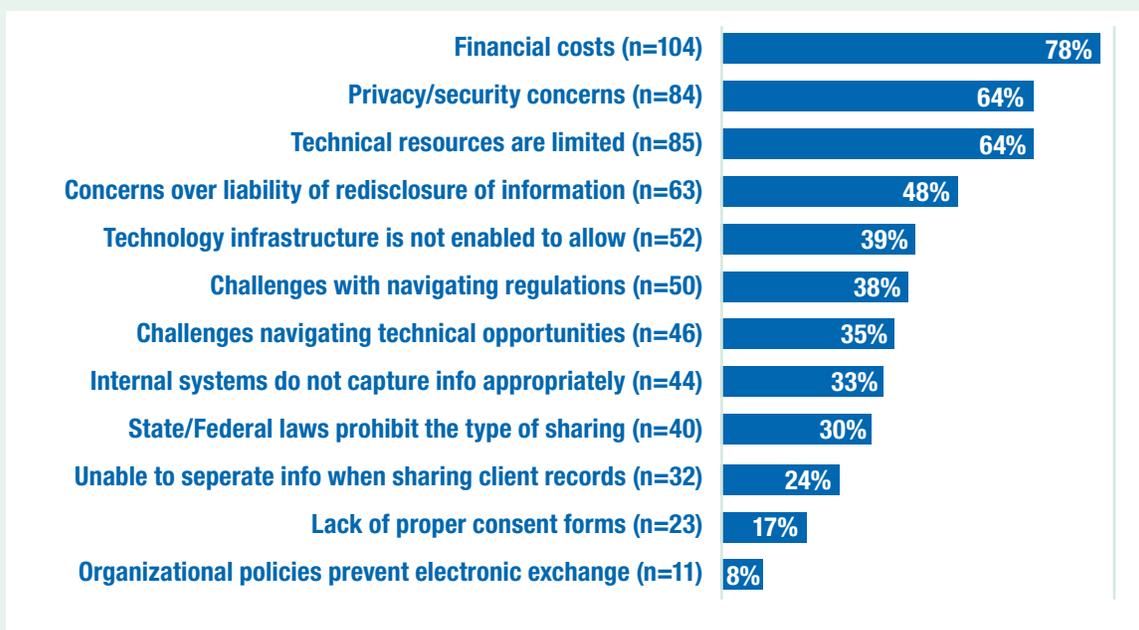
Note: n's (e.g., n=94) represent the number of respondents who provided a response.

Key result 3: In addition to resource barriers, privacy and security concerns are a top barrier to electronic information exchange.

Along with financial cost and limited technical resources, privacy and security concerns and redisclosure liability were listed as top barriers to sharing information. Other reported barriers related to this were challenges with navigating regulations (38%), state/federal laws prohibiting sharing (30%), inability to separate information when sharing client records (24%) and lack of proper consent forms (17%). This is not surprising given the additional protection required under 42 CFR Part 2 and the significant lack of clarity regarding what information can and cannot be shared.

42 CFR Part 2 is a federal regulation that applies to health information stored by certain substance use disorder treatment providers. It is more restrictive than HIPAA, with special requirements for release of information forms and other rules about sharing information. Lack of clarity about and challenges with the regulation's requirements have led to a climate in which behavioral health providers are unable (or are unsure if they are able) to share substance use disorder information, even when it may be relevant to care provided by other care team members. The regulation was updated in 2017, and some of the information sharing requirements were relaxed to improve care coordination. However, many providers continue struggling with lack of clarity about what the regulation allows and concerns about liability and privacy.

Figure 12: information sharing barriers (N=133)



Note: n's (e.g., n=104) represent the number of respondents who provided a response.

In-depth interview findings

Many interviewees cited privacy and security concerns with sharing client information. More than one agency reported that, even when the client signed a consent form, some clinicians remain unwilling to share relevant information. This limits their ability to share relevant information with the rest of the care team. One interviewee noted that the agency has a concern that patients might be less likely to seek substance use disorder treatment if their primary care provider could access that information. However, most interviewees expressed the value of and need for increased, less-restricted information flow to allow for improved care coordination.

Conclusion 3: Behavioral health stakeholders need more support and clarity about privacy and security of health information.

- **Need 3a:** Clear, consistent, reliable, actionable guidance about information sharing allowed under the law.
- **Need 3b:** Appropriate consent management tools and data segregation capability integrated into HIT/HIE products.

Key result 4: Data analytic tools and capabilities are necessary for improved patient care, reporting and practice management.

In addition to EHRs, a subset of behavioral health agencies have invested in data analytics (22%), population management (10%) and care coordination (13%) tools (see page D3). As in the physical health system of care, behavioral health providers are increasingly required to report various metrics and participate in value-based payment. As a result, they are increasingly prioritizing their data needs. This topic was not included in the survey. However, during stakeholder interviews, agencies discussed their need for data analytic capabilities to compile information for reporting (not only to the state, but also for reporting to satisfy various grant requirements), to help them manage their client needs, and to assist with business management.

Interviewees discussed using various approaches to data analytics, all of which were reported as critical. Some interview participants reported working with their vendors to build additional data capture and reporting capacity to support their needs. One (larger) agency reported pursuing additional data analytic support beyond its EHR's capability, including a data warehouse and data analytics tool.

Conclusion 4: Behavioral health agencies could benefit from additional resources and support for data analytics.

- **Need 4a:** Robust HIT and access to critical data to support data analytics and reporting.
- **Need 4b:** Data analytics tools and capabilities that meet behavioral health specific needs.
- **Need 4c:** Streamlined/consolidated reporting requirements where possible to decrease burden.

Appendix A

Behavioral Health HIT Workgroup Recommendations: Report to HITOC

Dec. 6, 2018

Executive summary

In response to a request from OHA's Health Information Technology Oversight Council (HITOC), OHA's Office of Health IT convened a Behavioral Health HIT Workgroup to provide input on the recommendations identified in the December 2017 draft Report on Health Information Technology and Health Information Exchange Among Oregon's Behavioral Health Agencies. The BH HIT Workgroup (workgroup) met three times: in September, October and November 2018. During this time, the workgroup identified its priority needs, made recommendations for meeting those needs, and prioritized the recommendations for HITOC's consideration.

The workgroup consisted of 11 representatives from a diverse set of behavioral health agencies. Members were highly engaged in the discussions, openly sharing their various perspectives. Though consensus was not required, the group largely agreed on both the list of recommendations and their prioritization. The list of priority recommendations is perhaps longer than expected but includes efforts and initiatives that (a) require higher and lower effort, (b) involve OHA and larger health systems and/or other organizations, and (c) address HIT/HIE needs across the behavioral health system.

The top priority recommendations identified by the workgroup to support the advancement of HIT/HIE within Oregon's behavioral health system include the following:

- 1 Support BH agencies without an EHR or with an insufficient EHR to adopt an EHR, including the following:
 - Develop a list of preferred EHR vendors to help support the EHR adoption/upgrade decision making process.*
 - Promote hospital/health systems' support for behavioral health EHR adoption/ upgrade.**Note:** Workgroup strongly supports financial support/incentives for BH agencies as well – federal and state incentives are proposed but not initiated.

* These recommendations were identified as foundational to other efforts to support HIT/HIE among BH.

2	<p>Continue existing work on HIE and bolster with additional strategies, including the following:</p> <ul style="list-style-type: none"> • Encourage larger organizations/hospitals/health systems to connect and contribute patient data to an HIE (e.g., Community Health Record). • Connect HIT systems to lower the effort required to access patient information across organizations (e.g., fewer clicks).[†] • Information sharing guidance/support related to privacy and security (e.g., 42 CFR Pt 2, HIPAA).^{*†} <p>Note: Workgroup strongly supports current work to provide access to HIE for BH providers, including PreManage and HIE Onboarding Program.</p>
3	<p>Support improved understanding of HIT/HIE, including the following:</p> <ul style="list-style-type: none"> • Provide HIT/HIE education.* • Create shared learning opportunities across a variety of topic areas (e.g., EHR adoption and use, HIE connectivity and use, data analytics/business intelligence, privacy and security). • Conduct landscape assessment of EHRs/HIE.*[†]
4	<p>Modernize state reporting systems to allow for improved interoperability with EHRs/HIE and data reporting back to agencies.[†]</p>

Additional recommendations identified by the workgroup include:

5	Provide support for e-referrals.
6	<p>Improve data definition, including:</p> <ul style="list-style-type: none"> • Universal data set • Universal data standards.
7	Support BH providers around data analytics/business intelligence including technical assistance and trainings (as organizations are ready).

The complete “Summary of BH HIT Workgroup recommendations” table is found on page A5–A12 of this appendix. It includes the recommendation context (which describes what need is being addressed and/or the expected benefit/outcome/change) and suggested strategies for HITOC’s consideration.

Given the critical input provided thus far, OHIT proposes to continue convening the BH HIT Workgroup on a quarterly basis in 2019. This group can be instrumental in providing input on HITOC/OHA’s future work to address these recommendations. Additional details and a list of proposed topics are listed in the body of the report.

[†] There is OHA work underway in these areas.

Workgroup background

The Health Information Technology Oversight Council (HITOC) is tasked with setting goals and developing a strategic health information technology plan for the state, as well as monitoring progress in achieving those goals and providing oversight for the implementation of the plan. HITOC is a committee of the Oregon Health Policy Board and works closely with the Office of Health Information Technology (OHIT) at the Oregon Health Authority to accomplish its work. Last year, OHIT conducted a Behavioral Health HIT Scan to gain a better understanding of the HIT/HIE landscape among behavioral health providers and organizations across the state, including their adoption and use of electronic health records (EHRs) and health information exchange (HIE). The report included staff-generated recommendations (informed by the scan results) for supporting the advancement of health information technology and exchange within Oregon's behavioral health system. HITOC requested that OHIT convene a workgroup consisting of behavioral health subject matter experts to confirm and assist in prioritizing the needs and recommendations identified in the report.

Workgroup objective

The high-level objectives of the Behavioral Health HIT Workgroup are to provide input and guidance on HIT/HIE initiatives and efforts affecting behavioral health in Oregon, and to provide strategic input to the Health Information Technology Oversight Council (HITOC) and Oregon Health Authority (OHA).

The workgroup is intended to be advisory and, therefore, does not need to come to consensus or to make formal recommendations as a group.

The workgroup's priority objective (for 2018 workgroup meetings) was to:

- Evaluate HITOC's BH Scan results and prioritize recommendations.

Future scope for the workgroup includes providing input on planned OHA work to support BH (potential scope for 2019 workgroup meetings), including:

- Development of a potential BH EHR/HIT incentive program (contingent upon funding)
- HIE Onboarding Program, which will support onboarding of key Medicaid clinics, including behavioral health agencies, to community-based HIE
- Development of potential technical assistance for behavioral health agencies related to HIT (contingent upon funding)
- Behavioral health information sharing toolkit and other consent and privacy issues.

Workgroup membership

Representatives from a variety of organizations with characteristics that represent the breadth of experiences in Oregon’s behavioral health landscape make up the BH HIT Workgroup. A guiding principle for panel composition is including a broad representation of system types and organizational roles, including technical and operational (e.g., IT managers, executive directors, behavioral health program managers) when possible. Members of the workgroup also represent both urban and rural areas within Oregon.

BH HIT Workgroup members (in alphabetical order)

Name	Title	Organization
Mark Arcuri	VP of Information Technology	Morrison Child and Family Services
Kacy Burgess	Clinical Information Systems Analyst	Deschutes County Health Services
Jeremiah Elliott	Senior Administrative Services Manager	Marion County Health & Human Services
Ashley Furrer	Behavioral Health Data Analyst	PeaceHealth
Denise Olson	Treatment Services Supervisor	Josephine County Community Corrections
Craig Rusch	CIO	Albertina Kerr
Steve Sanden	Executive Director	Bay Area First Step
Shelly Uhrig	COO	Options for Southern Oregon, Inc.
Juliana Wallace	Director, Unity Services	Unity Center for Behavioral Health
Jill Whiteford	Director of Quality and Program Evaluation	Catholic Charities of Oregon
Jeremy Wood	CIO	Central City Concern

Overview of workgroup meetings (2018)

Date	Topics	Outcomes
Sept. 20, 2018	<ul style="list-style-type: none"> • Workgroup context and purpose • Behavioral Health HIT Scan results • Discussion and prioritization of most pressing HIT/HIE needs 	List of priority HIT/HIE agency needs
Oct. 18, 2018	<ul style="list-style-type: none"> • Review, clarify, discuss and prioritize BH system needs • Identify recommendations 	List of recommendations for meeting the identified needs
Nov. 15, 2018	<ul style="list-style-type: none"> • HIE in Oregon <ul style="list-style-type: none"> » HITOC vision for statewide HIE » Network of Networks » HIT Commons » OHIT behavioral health-related efforts • BH HIT Workgroup recommendations for HITOC • Future of workgroup: topics and meeting schedule 	Prioritized list of recommendations

Future of workgroup

Building on the success of the BH HIT Workgroup's collaborative effort to prioritize the BH HIT Scan Report recommendations for HITOC, the workgroup will continue to meet on a regular basis (e.g., quarterly) in 2019. As noted in the workgroup objective section above, the future scope for the workgroup includes providing input on planned OHA work to support BH including:

- Development of a potential BH EHR/HIT incentive program (contingent upon funding)
- HIE Onboarding Program, which will support onboarding of key Medicaid clinics, including behavioral health agencies, to community-based HIE
- Development of potential technical assistance for behavioral health agencies related to HIT (contingent upon funding)
- Behavioral health information sharing toolkit and other consent and privacy issues.

In addition, the workgroup may be tasked with reviewing and providing further input on the recommendations and proposed strategies/approaches presented in this report including:

- A proposed collective source (e.g., database) for BH EHR/HIT information
- The development and dissemination of educational materials (including relevant HIT/HIE landscape information)
- Information dissemination to and further engagement with BH agencies (e.g., BH section on the OHIT website)
- Overhaul of MOTS reporting
- Informing PDMP integration efforts within behavioral health (e.g., value proposition, education/outreach opportunities).

Summary of BH HIT Workgroup recommendations

The following table summarizes the workgroup's individual rankings and group discussion of their proposed recommendations. The workgroup discussed their proposed recommendations as a group to develop overarching priorities and identify where recommendations were foundational or precursors to other work. The resulting top priority recommendations (in the executive summary) resulted from the final group discussion more so than from the individual tallied rankings; however, these rankings are provided below. Following the third meeting of the workgroup, members were asked to review the groupings/final order of the recommendations via email. Some recommendations will require further fleshing out. As noted above, OHA staff recommend continuing to convene the workgroup in 2019 to help with this process.

Workgroup recommendation table

Key to rankings (H=high, M=medium, L=low; numbers reflect how many workgroup members provided that rating):

- **Urgency rating:** Is the recommendation highly urgent (needed immediately) or a necessity, moderately important or merely a “nice to have” for improving HIT/HIE within BH?
- **Degree of impact rating:** Would pursuing the recommendation likely affect all/most, some, few stakeholders?
- **Level of effort rating:** Would pursuing the recommendation require a lot, some or minimal effort by OHA, BH stakeholders and/or others?

Recommendation priority	Recommendation	Context (e.g., what need is it addressing?)	Suggested approaches or strategies (for HITOC's consideration)	Priority/urgency	Degree of impact	Level of effort	Workgroup member notes (e.g., additional strategies, more context, considerations)
1	Develop a list of preferred EHR vendors to help support the EHR adoption/upgrade decision making process.	Many behavioral health agencies face challenges with EHR selection, which is often a resource-intensive process consuming significant amounts of staff time and money often resulting in disappointing results.	<ul style="list-style-type: none"> • Compile and make available a list of EHR vendors that: <ul style="list-style-type: none"> » Are interoperable (“play better with others”) » Are high functioning » Are HIE capable/connected » Meet data standards » Capture needed data » Have data analytic/reporting capabilities » Are affordable. • Compile and make available a list of EHR vendor comparison tools available on the market/Web. • Provide guidance on critical EHR functionality needed to support vision for health care system information sharing. • Provide an EHR assessment tool. 	5-H 1-M 4-L	3-H 3-M 2-L	2-H 1-M 6-L	<ul style="list-style-type: none"> • Foundational. Pursue prior to EHR adoption support/efforts. • If agencies are to invest in an EHR, they need to know which ones are most useful. • What really may be helpful is if someone has determined if the systems meet meaningful use and such. • Need to understand what we are/are not adopting. • Need information about EHR strengths and weaknesses. • Basic information re what is required (e.g., functionality, standards for HIE) would be helpful. • How to assess a vendor would be critical information. (Are there federal resources/efforts on this?)

Recommendation priority	Recommendation	Context (e.g., what need is it addressing?)	Suggested approaches or strategies (for HITOC's consideration)	Priority/urgency	Degree of impact	Level of effort	Workgroup member notes (e.g., additional strategies, more context, considerations)
2	Provide information sharing guidance/support related to privacy and security (e.g., 42 CFR Pt 2, HIPAA).	There are many misconceptions regarding what information can be shared with whom. Further clarity will encourage increased info sharing (MH, psychiatric, and SUD) and improve care coordination and patient care.	<ul style="list-style-type: none"> • Technical assistance/education • Legal assistance • HIEs may also need TA/legal assistance to ensure adequate protection of SUD info. • State to play a role in providing guidance and/or facilitating conversations to resolve issues/clarify regulations/law. 	8-H 2-M 0-L	7-H 3-M 0-L	1-H 4-M 1-L	<ul style="list-style-type: none"> • Foundational for HIE adoption and use. • Essential. • Big priority. • Important for major hosted EHRs with footprint in Oregon/ Epic to allow episodic restriction to align with 42 CFR Part 2.
3	Support BH agencies to adopt an EHR if agencies do not have an EHR or have an insufficient EHR.	Need to get more BH agencies onto an EHR to increase the BH system's ability to share information and coordinate care. Many currently implemented EHRs inadequately support the information sharing, care coordination and data analytic/reporting needs.	<ul style="list-style-type: none"> • Health systems could provide support, such as extending their EHR to BH agencies (e.g., Epic's Community Connect model). • Financial assistance (e.g., EHR Incentive Program for BH) • EHR selection assistance • Technical assistance for staff training, workflows adjustments 	7- H 3-M 0-L	4-H 4-M 0-L	7-H 3-M 0-L	<ul style="list-style-type: none"> • Need vendor list before pursuing adoption. • EHR selection needs to be done first, before adoption. • This is about assistance to meet minimum requirements. • Getting everyone with the same technology capabilities would help equalize the system and ensure better care.

Recommendation priority	Recommendation	Context (e.g., what need is it addressing?)	Suggested approaches or strategies (for HITOC's consideration)	Priority/urgency	Degree of impact	Level of effort	Workgroup member notes (e.g., additional strategies, more context, considerations)
4	Promote hospital/health systems' support for behavioral health EHR adoption/upgrade.	Most BH agencies are either without an EHR or use an EHR that inadequately supports their info sharing and data analytic/reporting needs. Health Systems' support of BH EHR adoption/upgrade is mutually beneficial as it increases electronically available patient data (e.g., more complete health record) and promotes information sharing for improved care coordination.	<ul style="list-style-type: none"> Showcase success stories in Oregon. OHA to collaborate with health care organizations (e.g., payers, HIEs, Health Systems already supporting BH) to document a business case to encourage investment in/supporting HIT/HIE progress within Oregon's BH system. Consider ways to incentivize/motivate health systems. 	6-H 4-M 0-L	5-H 5-M 0-L	5-H 4-M 0-L	<ul style="list-style-type: none"> High priority recommendation Most important for us
5	Encourage larger organizations/hospitals/health systems to connect and contribute patient data to an HIE (e.g., Community Health Record).	Hospital/health systems connecting to an HIE contribute to a tipping point, creating a value proposition for smaller agencies/organizations to follow suit.	<ul style="list-style-type: none"> OHA to collaborate with health care organizations (e.g., HIEs, HIE-connected health systems) to document a business/"public good" case for encouraging HIE connectivity. Showcase the benefits of existing health system connections. 	7-H 3-M 0-L	8-H 2-M 0-L	7-H 3-M 0-L	<ul style="list-style-type: none"> Other agencies will follow if the major hospitals contribute. It is a top priority. High priority for many workgroup members.
6	Provide HIT/HIE education.	Many misconceptions exist regarding EHR and HIE definitions, capabilities, and roles (e.g., using the same EHR vendor will result in access to another agency's information), contributing to confusion, frustration, and delayed/decreased HIT/HIE adoption.	<ul style="list-style-type: none"> Further assess HIT/HIE education needs. Provide educational materials via various means (e.g., website, webinar, etc.). Make information about relevant non-OHA educational opportunities available. Continue disseminating information about OHA efforts and initiatives. 	1-H 5-M 4-L	1-H 7-M 1-L	0-H 3-M 6-L	<ul style="list-style-type: none"> It is foundational. Getting everyone on the same page will be important to having meaningful conversations going forward.

Recommendation priority	Recommendation	Context (e.g., what need is it addressing?)	Suggested approaches or strategies (for HITOC's consideration)	Priority/urgency	Degree of impact	Level of effort	Workgroup member notes (e.g., additional strategies, more context, considerations)
7	Create shared learning opportunities across a variety of topic areas (e.g., EHR adoption and use, HIE connectivity and use, data analytics/BI, privacy and security).	Agencies are acutely aware of the value of learning from others' successes and challenges (i.e., lessons learned). There is a strongly felt need to collaborate with other agencies to accelerate HIT/HIE progress across the BH system.	<ul style="list-style-type: none"> Support shared learning by: <ul style="list-style-type: none"> Disseminating relevant HIT/HIE information Informing agencies of already existing opportunities Encouraging participation Convening and facilitating. 	1-H 6-M 3-L	1-H 8-M 1-L	1-H 6-M 3-L	<ul style="list-style-type: none"> Agencies have had experiences with different platforms. Just getting a forum together would go a long way toward a discussion about EHR vendors. Need information from other folks on the ground to share and learn about different platforms.
8	Modernize state reporting systems to allow for improved interoperability with EHRs/HIE and data reporting back to agencies.	Most agencies face challenges when interacting with state reporting systems (e.g., MOTS), which causes a drain on resources. In addition, agencies would benefit from OHA-provided reports, based on required data submissions.	<ul style="list-style-type: none"> Consider HIT standards implemented by EHRs/HIEs when modernizing their reporting system(s) to allow for/support full, bi-directional data sharing. OHA to make collected data available in the form of meaningful reports. 	8-H 2-M 0-L	6-H 3-M 0-L	6-H 2-M 1-L	<ul style="list-style-type: none"> It is a very high priority. We spend a significant amount of time reporting on MOTS data. Work is being done to modernize the MOTS-related systems. Team is gathering input to align with HIE efforts already underway.

Recommendation priority	Recommendation	Context (e.g., what need is it addressing?)	Suggested approaches or strategies (for HITOC's consideration)	Priority/urgency	Degree of impact	Level of effort	Workgroup member notes (e.g., additional strategies, more context, considerations)
9	Connect HIT systems to lower the effort required to access patient information across organizations (e.g., fewer clicks).	Agencies often need to implement/connect to multiple systems to have access to needed patient information (e.g., EHR, PreMange, HIE), which makes accessing the information labor-, time-, and resource-intensive.	<ul style="list-style-type: none"> Continue pursuit of a Network of Networks that connects various HIT systems. 	6-H 3-M 1-L	7-H 3-M 0-L	8-H 2-M 0-L	<ul style="list-style-type: none"> Find a way to connect systems to facilitate the sharing of information, with few(er) clicks. High priority, impact and efforts. We can continue to implement a multitude of systems, but until we connect/integrate them or combine functionalities, provider utilization will remain low. EHR adoption among BH needs to come first; this seems like it is further down the road.
10	Landscape assessment of EHRs/HIE	Increased awareness of EHR adoption/HIE use by region could support creation of user groups, highlight gaps in adoption, regional HIE readiness, degree and type of already occurring info exchange.	<ul style="list-style-type: none"> Support gathering EHR/HIE info to assist with adoption efforts, shared learning, information dissemination. Agencies/organizations to report on EHR/HIE use. OHA to collect, compile and make EHR/HIE landscape information available. 	2-H 5-M 2-L	3-H 3-M 3-L	0-H 5-M 4-L	<ul style="list-style-type: none"> It is foundational; it informs where we are relative to where we need to be. Seems like this would be low hanging fruit. It would be helpful to know what HIE vendors are available. So much depends upon understanding the regional and statewide landscape. The concept of user groups is great, but you need to be on the same system.

Recommendation priority	Recommendation	Context (e.g., what need is it addressing?)	Suggested approaches or strategies (for HITOC's consideration)	Priority/urgency	Degree of impact	Level of effort	Workgroup member notes (e.g., additional strategies, more context, considerations)
11	Provide support for e-referrals.	Most referrals are received on paper via fax – significant time is spent scanning, processing, faxing. An effective e-referrals system is critical to improved care coordination and patient care.	<ul style="list-style-type: none"> Assist with facilitating process to standardize behavioral health e-referrals. Promote standardized process among all Oregon entities to support e-referrals across the health care continuum. 	3-H 4-M 3-L	5-H 2-M 3-L	3-H 3-M 2-L	<ul style="list-style-type: none"> Important for coordination of care and reduced administrative costs. Need to electronically streamline process, which would save costs and facilitate care coordination. Need a community standard for e-referrals. (Epic users handle referrals via fax due to already established workflows.) Need hospitals to agree; not easy to get them to adopt. Given the cultural and workflow shifts needed across the health care system to support broader use of e-referrals, this work is likely to be longer-term effort. We need ROIs; can't have a referral without an ROI.
12	Define universal data set.	The lack of a standard/universal data set is the source of many HIE challenges. To define/implement such a data set would allow for increased electronic information exchange to support patient care.	<ul style="list-style-type: none"> Define, based on federal and state reporting requirements. Collaborate with HIEs to ensure consistency/feasibility. Convey to EHR vendors. 	7-H 2-M 1-L	7-H 2-M 0-L	4-H 2-M 1-L	

Recommendation priority	Recommendation	Context (e.g., what need is it addressing?)	Suggested approaches or strategies (for HITOC's consideration)	Priority/urgency	Degree of impact	Level of effort	Workgroup member notes (e.g., additional strategies, more context, considerations)
13	Define universal data standards.	An industry-wide standard of interfacing with different systems (allowing for bi-directional capability) would significantly improve the BH/health care system.	<ul style="list-style-type: none"> Define based on federal standards. Develop consistency across departments/requirements. 	5-H 4-M 1-L	6-H 3-M 0-L	5-H 2-M 1-L	<ul style="list-style-type: none"> Would be wonderful but extremely difficult. Leverage federal efforts, where/when possible.
14	Support BH providers around data analytics/business intelligence including technical assistance and trainings (as organizations are ready).	Many agencies lack knowledge and resources for data analytics and population health management (e.g., understand their populations' needs). Also need resources for data-driven decision making to support the agency with reporting, financial management, forecasting and productivity tracking.	<ul style="list-style-type: none"> Provide and/or support TA/training for data analytics/BI. 	0-H 5-M 5-L	2-H 4-M 3-L	2-H 6-M 1-L	<ul style="list-style-type: none"> Lower priority. Agencies that most need this assistance won't have the staff necessary to carry it out. Since this supports individual agencies rather than the BH/health care system, consider it lower priority.

Appendix B

Table of policy context topics, description and effect, and links for additional information

Policy context topic	Description and impact
Oregon Health Policy Board's Action Plan for Health	<p>Oregon Health Policy Board's Action Plan for Health, created in 2010 and refreshed in 2017, sets a clear direction for advancing health in Oregon. Behavioral health system improvements are a key focus area within the plan. HIT plays a critical role in several key initiatives, including expanding the coordinated care model; integrating physical, behavioral and oral health; and moving upstream to address the social determinants of health. See https://apps.state.or.us/Forms/Served/le9963.pdf.</p>
Behavioral Health Collaborative	<p>In 2016, OHA convened a diverse group of nearly 50 individuals from across the state representing every part of the behavioral health system. This group, the Behavioral Health Collaborative (BHC), was brought together to inform the transformation of Oregon's behavioral health system. After eight months of work, the BHC published recommendations designed to help Oregonians get the right support at the right time. One of the four overarching recommendations is to "strengthen Oregon's use of health information technology and data to further outcome-driven measurement and care coordination..." This recommendation includes a series of action items to improve behavioral health information sharing and reduce barriers to data access. See http://www.oregon.gov/oha/HPA/CSI-BHP/Pages/Behavioral-Health-Collaborative.aspx.</p>
Health Information Technology Oversight Council (HITOC)	<p>Oregon's Legislature charged HITOC with overseeing the Oregon HIT Program, monitoring the state's HIT landscape, developing long-term strategies to advance HIT, and making recommendations to the Oregon Health Policy Board and the Oregon Congressional delegation. HITOC reports to the OHPB, which sets HITOC priorities and membership, endorses HITOC recommendations and guides HITOC work to ensure Oregon's health system transformation efforts are supported by the right HIT. See http://www.oregon.gov/oha/HPA/OHIT-HITOC/Pages/About-Us.aspx.</p>
HIT Oversight Council (HITOC) and Oregon's Strategic Plan for HIT/HIE (2017–2020)	<p>Oregon's HIT Oversight Council (HITOC), which reports to the OHPB and is guided by its Action Plan for Health, is tasked with setting goals and developing a strategic HIT plan for the state. The OHPB identified behavioral health as a priority for HITOC's workplan. The HITOC is also the stakeholder group charged with developing the HIT workplan for the BHC's transformation efforts. Oregon's Strategic Plan for HIT/HIE 2017–2020 lays out HITOC's vision and strategies for an HIT-optimized health care system, which includes meaningful participation by behavioral health providers and patients. See http://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/OHA%209920%20Health%20IT%20Final.pdf.</p>
Certified Community Behavioral Health Clinic (CCBHC) Demonstration Program	<p>The CCBHC Demonstration Program is a federal pilot initiative through 2019 to expand access to behavioral health care in community-based settings and transform payment for behavioral health providers to a value-based model, requiring the use of HIT for care improvement and metrics tracking and reporting. The program prioritizes increasing the adoption of technology for improved care, including data collection, quality reporting and other activities that support providers' ability to care for individuals with co-occurring disorders. OHA applied for and was selected to be one of eight states to participate in the CCBHC Demonstration Program, and 13 Oregon behavioral health agencies are participating in the program. See http://www.oregon.gov/oha/HPA/CSI-BHP/Pages/Community-BH-Clinics.aspx.</p>

Appendix C

Oregon HIT Program descriptions

Oregon Health Information Technology Program

Oregon's coordinated care model increasingly relies on access to patient information and the health information technology (HIT) infrastructure to share and analyze data. Optimization of the health care system through the right technology tools is a key part of Oregon's efforts to better coordinate care, improve outcomes and lower cost for all Oregonians.

OHA's Office of Health Information Technology (OHIT) serves as a partner and resource for both state programs and other public and private users of health information technology. OHIT provides effective health information technology policies, programs and partnerships that support improved health for all Oregonians.

Passed in 2015, House Bill 2294 advances the state's HIT efforts by establishing the Oregon HIT Program within OHA. The bill expands OHA's ability to offer HIT services beyond Medicaid to the private sector and provides OHA greater flexibility in working with stakeholders and partners. HB 2294 also updates the role of the HIT Oversight Council (HITOC) and directs HITOC to report to the Oregon Health Policy Board.

Partnerships

HIT Commons

The Oregon Health Leadership Council (OHLC) and OHA, along with many stakeholders, created a public/private HIT governance partnership for Oregon known as the HIT Commons. A shared governance model helps accelerate HIT adoption and use across Oregon, leverage public and private investments, expand access to high-value data sources

HIT vision and goals

In an HIT-optimized health care system:

- Oregonians have their core health information available where needed so their care team can deliver person-centered, coordinated care.
- Clinical and administrative data are efficiently collected and used to support quality improvement and population health management, and to incentivize improved health outcomes. Aggregated data and metrics are also used by policymakers and others to monitor performance and inform policy development.
- Individuals and their families access, use and contribute their clinical information to understand and improve their health and collaborate with their providers.

(see EDIE and PDMP Gateway below), and advance a network of networks approach to health information exchange. **Launched January 2018.**

Emergency Department Information Exchange

In 2015, OHA partnered with OHLC to launch the Emergency Department Information Exchange (EDIE) Utility in Oregon. EDIE and PreManage provide real-time notifications of emergency room and hospital events as well as care recommendations for patients who frequently visit the emergency department. The programs' goal is to reduce avoidable hospital utilization and improve health outcomes. EDIE Utility is a public/private partnership to fund and govern the EDIE infrastructure. **EDIE Utility was encompassed under the HIT Commons in 2018.**

Programs and services

PreManage for Medicaid organizations

PreManage complements EDIE, allowing hospital event data to be pushed to health care organizations outside the hospital setting in real-time. Notifications inform providers, health plans, coordinated care organizations and health systems when their patients or members are seen in an emergency department or hospital, allowing them to intervene—in real-time, if needed—with individuals who are high utilizers of emergency department services.

- Organizations may subscribe to PreManage for their members or patients, and health plans or CCOs may sponsor subscriptions to PreManage for their key clinics. Since 2016, OHA has sponsored a subscription for many Medicaid organizations.

Oregon's Prescription Drug Monitoring Program (PDMP) Integration initiative

- Accurate and timely PDMP information at the point of care reduces inappropriate prescriptions, improves patient outcomes and promotes informed prescribing practices. The PDMP Integration initiative connects EDIE, regional or private health

Program status, as of February 2019

- **PreManage:** All CCOs, most commercial health plans and more than 300 physical, behavioral and dental clinics are participating.
- **PDMP Integration initiative:** More than 5,900 prescribers, 87 health care entities and two retail pharmacies (representing 240 pharmacists) are live with PDMP integrated directly into their health IT system, through EDIE alerts or through their HIE.
- **Medicaid and Medicare EHR Incentive Programs and OMMUTAP:** More than 8,400 Oregon providers and 61 hospitals have received approximately \$526 million through the Medicaid or Medicare EHR incentive programs. OHA launched OMMUTAP in 2016 through a contract with OCHIN and has enrolled more than 1,571 providers at 371 clinics.
- **Flat File Directory for Direct secure messaging:** This contains more than 16,000 addresses across 24 entities that represent more than 709 unique health care organizations.

information exchanges (HIEs), electronic medical/health records and pharmacy management systems to Oregon's PDMP registry. PDMP data can now be brought directly into prescriber and pharmacist health IT for one-click access to controlled substance prescription data, eliminating the need to access a separate web portal. A statewide subscription for PDMP data integration into health IT was launched through the HIT Commons in spring 2018.

Medicaid EHR Incentive Program and OMMUTAP

- The Medicaid Electronic Health Record (EHR) Incentive Program provides incentive payments to eligible health care providers and hospitals to support their investments in EHRs and other HIT. Incentives are available for adopting and demonstrating the meaningful use of certified EHR technology. Program Year 2016 was the last year to start the multi-year incentive program. The program runs through 2021.
- The Oregon Medicaid Meaningful Use Technical Assistance Program (OMMUTAP) helps Oregon's eligible Medicaid providers adopt and use certified EHR technology and meet requirements for federal EHR incentive programs. The program ends May 2019.

Flat File Directory for Direct secure messaging

Direct secure messaging is a HIPAA-compliant, secure method for exchanging any protected health information. Providers and hospitals commonly use it to send transition of care summaries. The Flat File Directory is Oregon's combined address book for Direct secure messaging addresses, allowing participants to find or discover Direct addresses outside their own organizations.

Health Information Exchange Onboarding Program

The Health Information Exchange (HIE) Onboarding Program is designed to advance the exchange of information across Oregon's Medicaid provider network, to support care coordination among providers supporting the same patient. The program will leverage 90 percent federal funding to support the initial costs of connecting (onboarding) priority Medicaid providers to community-based HIEs. Priority Medicaid providers include behavioral health providers, oral health providers, critical physical health providers and others. Later phases include onboarding

- **HIE Onboarding Program:** Community-based HIEs can help meet critical Medicaid providers' HIE needs through a wide range of HIE services that support referrals, coordination of care, and transitions of care.
- **Clinical Quality Metrics Registry:** With the increasing adoption of EHRs, Oregon has new opportunities to measure and improve the quality of care. Using EHR data improves the ability to measure outcomes — for example, measuring whether a diabetic patient's blood sugar levels are controlled rather than simply measuring whether the patient's blood sugar levels were tested. The CQMR will enable more efficient collection and use of this important quality data.
- **Oregon Provider Directory:** The ability for health care entities to use one trusted, single and complete source of provider data is essential to improving system efficiencies and patient care coordination.

long-term services and supports, social services and other critical Medicaid providers. **Launched in January 2019.**

Clinical Quality Metrics Registry

This statewide registry will collect clinical quality data for Oregon’s Medicaid program, including required performance metrics for CCOs and the Medicaid EHR Incentive Program. Over time, the CQMR may support additional programs to enable a “report once” strategy, where providers could send data to the CQMR to meet requirements for multiple reporting programs and thus reduce administrative burdens. The program is funded through 90 percent federal match and will initially support Medicaid-related reporting. **Launched in January 2019.**

In development

Oregon Provider Directory

This state-level provider directory will be a source of accurate health care practitioner and practice setting information that can be accessed by health care entities, such as providers, care coordinators, CCOs, health plans and state agencies. The Oregon Provider Directory will leverage data from existing, trusted data sources, including the Oregon Common Credentialing Program. The program is funded through 90 percent federal match and will initially support Medicaid-related organizations. **Launching in 2019.**

Federal/state program participation and other priority agencies

Some behavioral health agencies participate in federal and/or state programs designed to provide comprehensive, innovative and/or priority population-focused services that often require additional reporting. Other priority agencies are those that serve high-priority populations, such as Tribal and medically-underserved and/or are affiliated with a physical health organization. Agencies can fall under more than one category (e.g., CMHP and CCBHC).

Federal/state program/other priority agency type	Total number of agencies	Surveys completed	Response rate
Assertive Community Treatment (ACT) Team	33	21	64%
Behavioral Health Home (BHH)	10	8	80%
Certified Community Behavioral Health Clinic (CCBHC)	13	9	69%
Community Mental Health Program (CMHP)	30	20	67%
Federally Qualified Health Center (FQHC)	16	8	50%
Physical Health Organization Affiliated	21	11	52%
Tribal Organization	7	6	86%

Electronic health records

EHR vendors

The survey asked agencies about their current use of EHRs, including vendor information. Most (76%) responding agencies reported using an EHR. Behavioral health agencies have implemented many different EHRs across the state, with the top three being Credible, CareLogic's Qualifacts, and Epic.

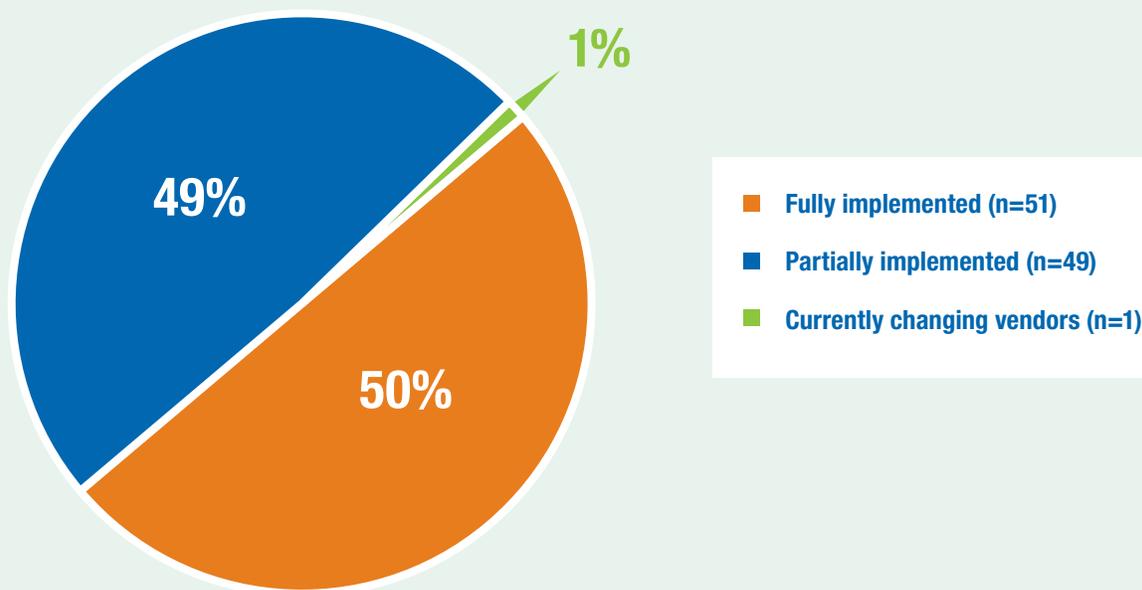
EHR	#	EHR	#	EHR	#	EHR	#	EHR	#
Credible	11	BestNotes	2	TherapyNotes	2	ClinicTracker	1	NueMD	1
CareLogic – Qualifacts	10	Dr Cloud	2	Valant	2	CounSol	1	Procentive	1
Epic	8	Exym	2	ABRIZE	1	Echo	1	CoCENTRIX Pro-Filer	1
NextGen	6	ICANotes	2	AccuCare	1	Eldermark	1	Psych Advantage	1
myEvolv	4	Methasoft	2	Advanced Data Systems	1	Essentia	1	Salesforce	1
OCHIN – Epic	4	myAvatar	2	AdvancedMD	1	Kaleidacare	1	Therabill	1
Office Ally	4	Prime Suite	2	Apricot	1	KeyNotes	1	TheraNest	1
OWITS	4	Raintree	2	CareCloud	1	Kipu	1	TherapyMate	1
Centricity – GE Healthcare	3	RPMS	2	Celerity	1	MethodOne	1	TheraScribe	1
Clinicians Desktop – The Echo Group	3	Sigmund	2	Cerner	1	MyHelper	1	Netsmart TIER	1

Note: Some agencies reported using more than one EHR.

Status of EHR implementation

Agencies were also asked whether they have fully (all patient information in electronic format, all sites, no paper chart utilization) or partially (some to most patient information in electronic format, some paper charts utilized) implemented their EHR. All but one agency's EHRs were partially or fully implemented, with half being fully implemented.

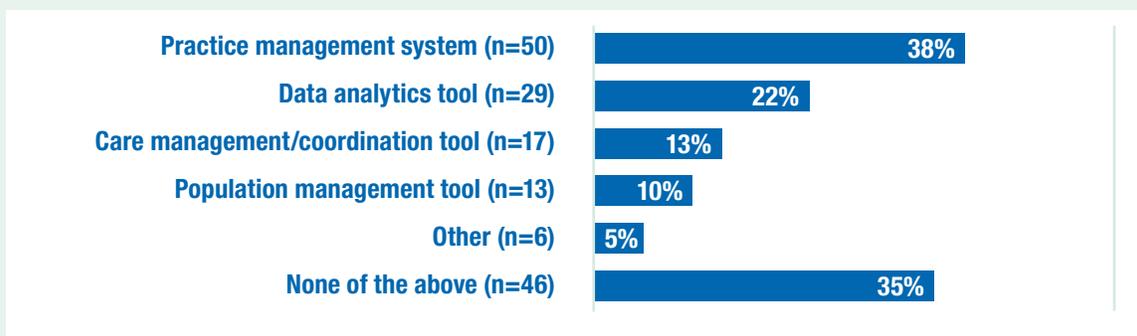
Figure 2: Status of implementation (N=101)



Other types of IT used

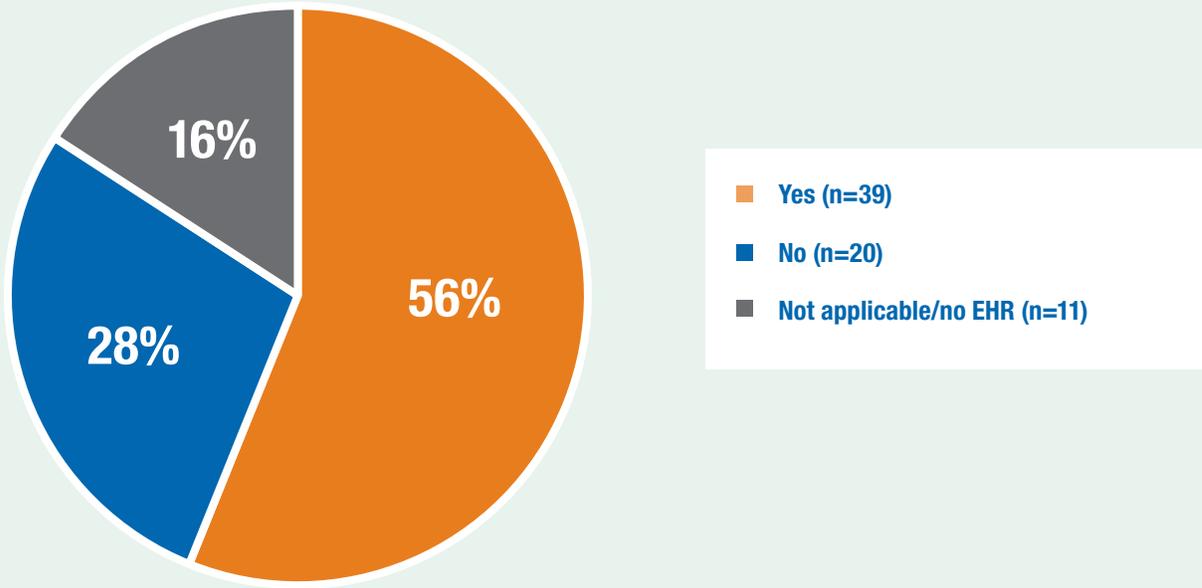
Agencies were asked about other types of IT used in addition to an EHR and whether the tools were integrated with the EHR. A practice management system is the most commonly reported other IT implemented. When other technologies are in use, more than half were also integrated with the EHR.

Figure 3: Other non-EHR IT use (N=133)



Note: n's (e.g., n=50) represent the number of respondents who provided a response.

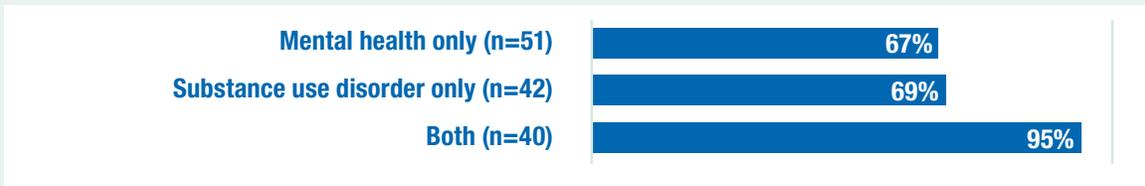
Figure 4: IT tools integrated with EHR (N=70)



Sub-analyses: Program type(s): Substance use disorder, mental health or both

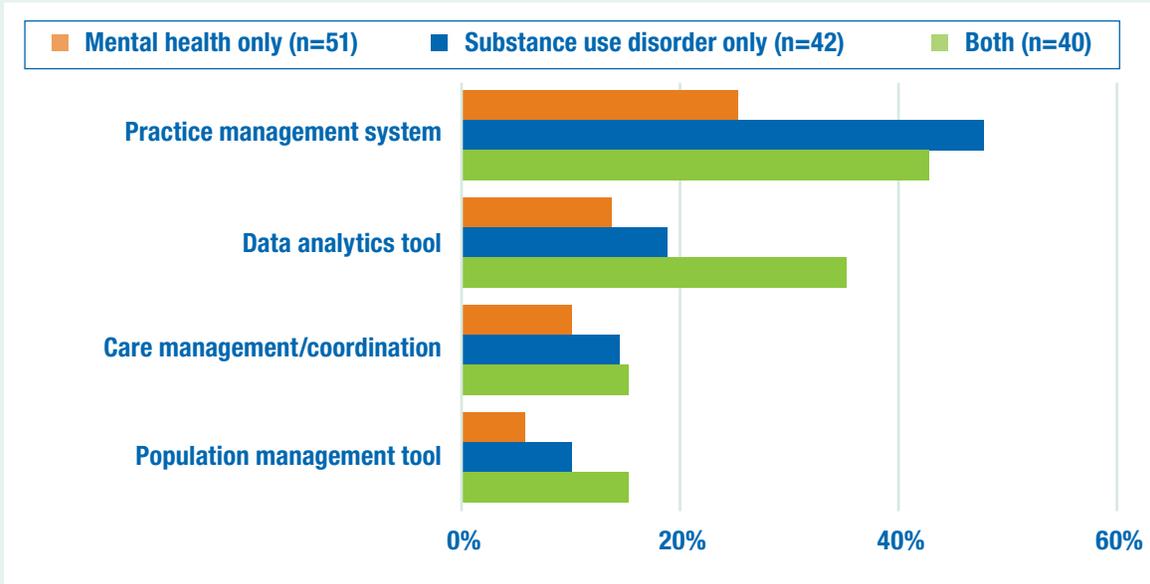
Agencies were categorized by the type of licensed behavioral health programs they offer as substance use disorder (SUD) only, mental health only or both. Though the six licensed programs do not cover the entirety of behavioral health care, they do provide an objective measure of program type. Agencies that operate both types of programs have higher levels of EHR adoption; agencies that provide only mental health treatment use other health IT less than other agencies.

Figure 5: Current EHR use (N=133)



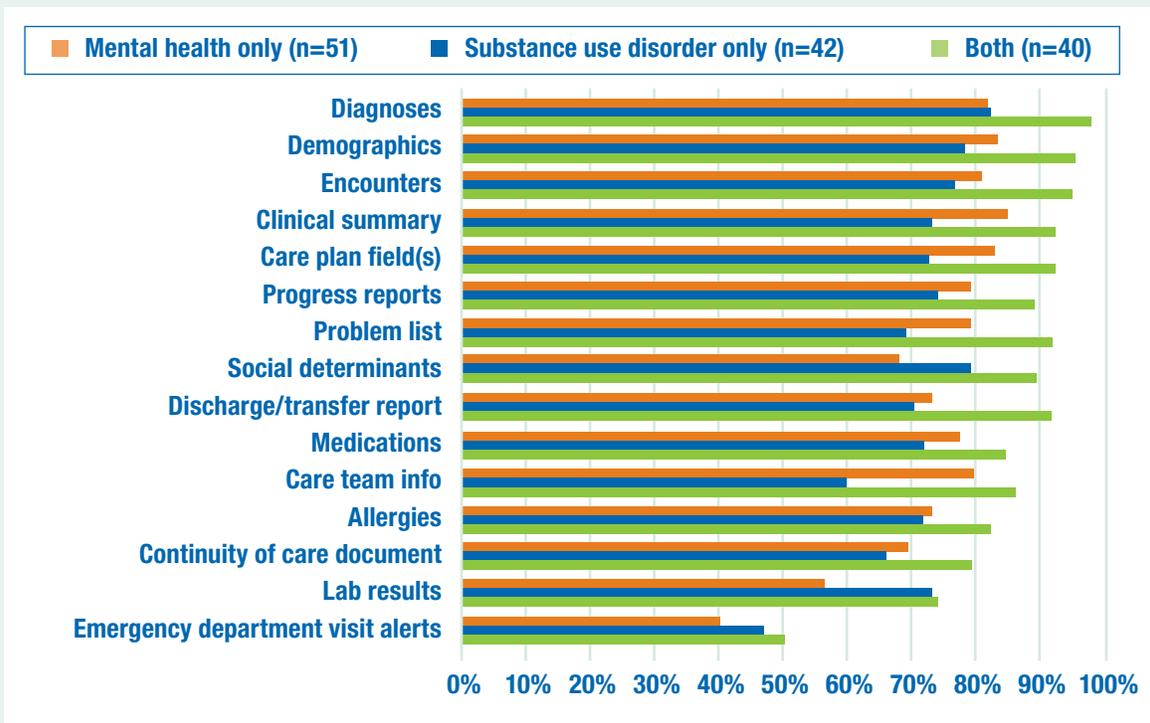
Note: n's (e.g., n=51) represent the number of respondents who provided a response.

Figure 6: Other IT use (N=133)



Agencies that provide both SUD and mental health treatment also capture more data electronically, while SUD-only agencies generally capture the least.

Figure 7: Type of data captured electronically



Physical health integration

Onsite physical health provider

Agencies were asked whether they provide onsite physical health services, the type of charting/EHR used by any onsite physical provider(s), and who at the agency other than physical health staff have access to electronic physical health information. More than one-third of the agencies (41%) reported having an onsite physical health provider. Of those, 89% use an EHR or a combination of paper and an EHR for their charting method.

Figure 8: Onsite physical health provider (N=129)

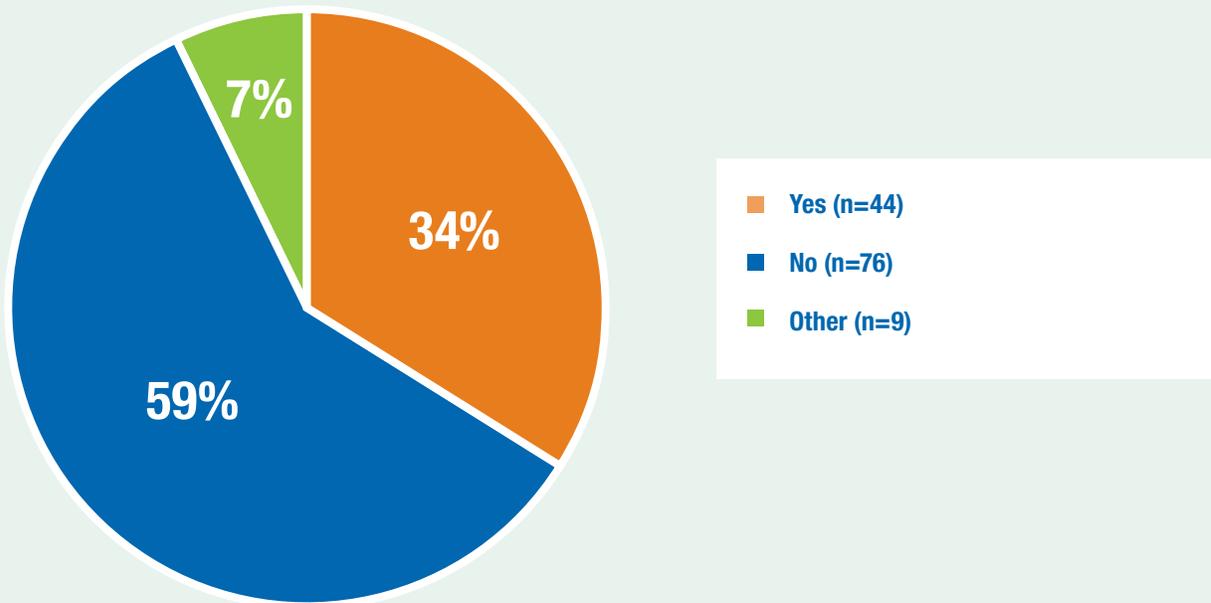
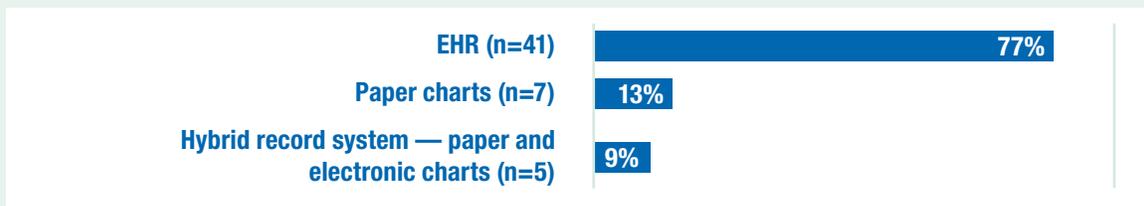


Figure 9: Charting method used by physical health provider (N=53)



For those using an EHR, the same EHR is typically being used by both the physical and behavioral health providers. For the vast majority, at least some behavioral health staff have access to physical health information in the EHR; slightly less than half give access to all behavioral health staff.

Figure 10: EHR used by physical and behavioral health provider (N=41)

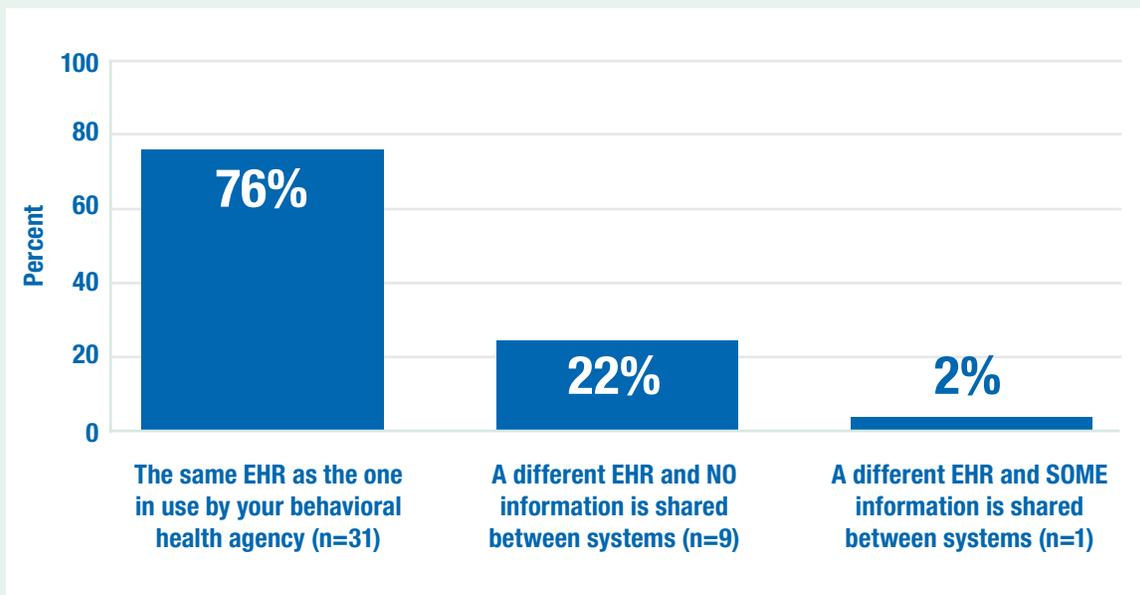
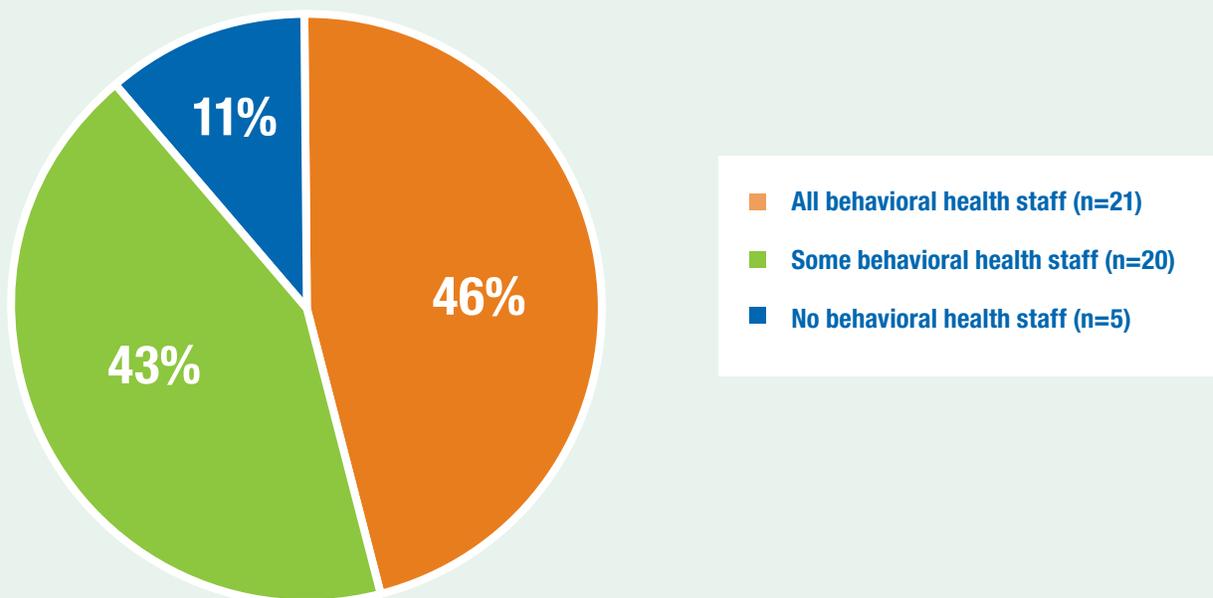


Figure 11: Access to physical health information in the EHR (N=46)



Sub-analyses: Part of larger physical health organization

In addition to asking survey respondents whether they offered onsite physical health services, the Office of Health Information Technology researched each responding agency to determine if they are part of a larger organization that also provides physical health services. The majority of agencies were behavioral health only organizations, but 30% were part of a larger organization that also provides physical health services. Those agencies that provide physical health in addition to behavioral health services had slightly higher EHR use, much higher other health IT use, and more frequent capture of data.

Figure 12: Current EHR use by whether agency is part of larger organization that also provides physical health services (N=133)

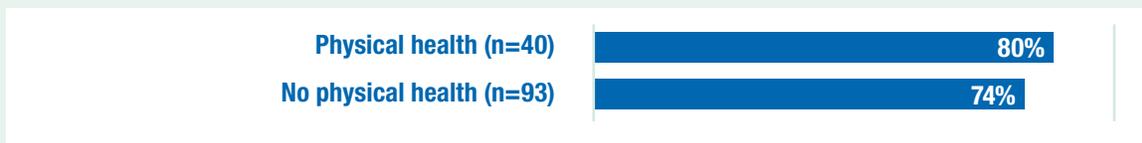


Figure 13: Other IT use, by whether agency is part of larger organization that also provides physical health services (N=133)

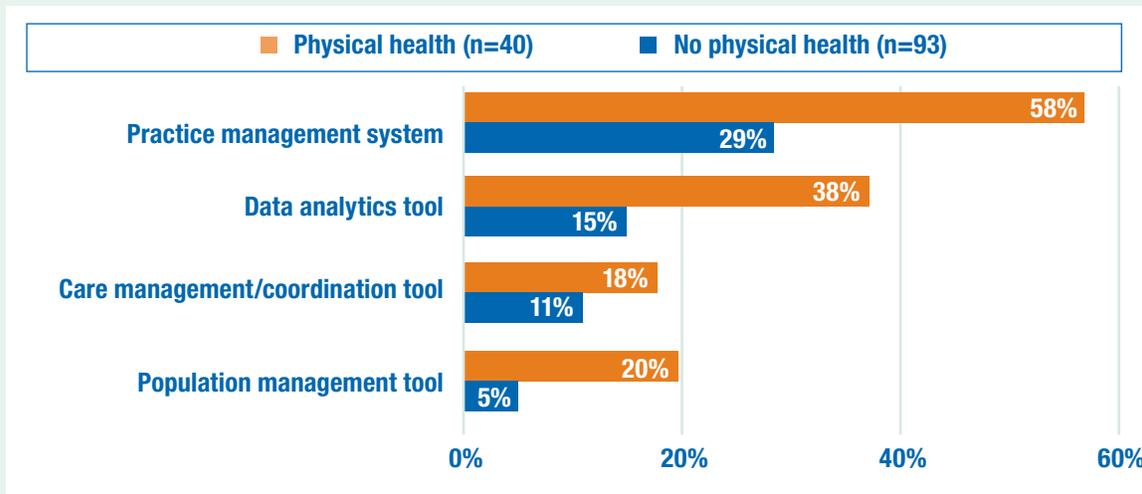
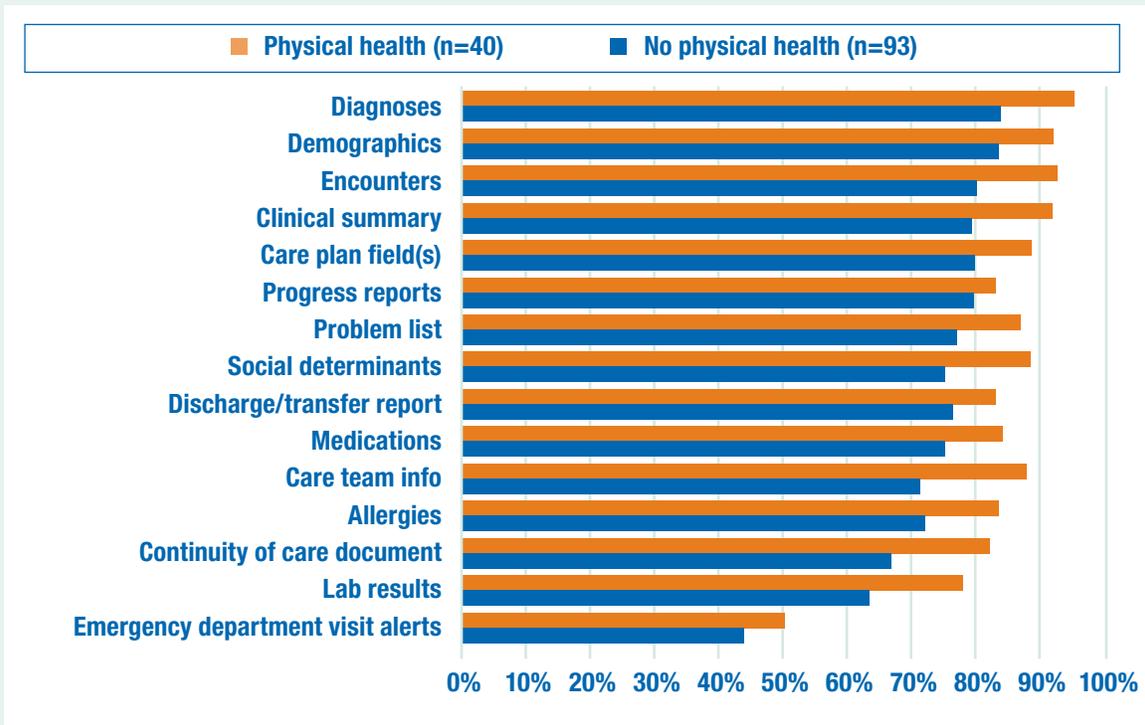


Figure 14: Type of data captured electronically, by whether agency is part of larger organization that also provides physical health services (N=133)



Sub-analyses: Agency size and physical health services

As previously stated, our definition of agency size – the number of licensed programs – is imperfect. One aspect it fails to capture is what other services the agency provides. Some agencies are dedicated to behavioral health while others are part of larger organizations that also offer physical health.

Small, standalone behavioral health agencies (those with between one and five licensed behavioral health programs) have lower rates of EHR use and information capture than small behavioral health agencies within a physical health agency or larger agencies (those with six or more licensed programs) regardless of whether they provide physical health.

Figure 15: Percent currently using EHR, by size (N=133)

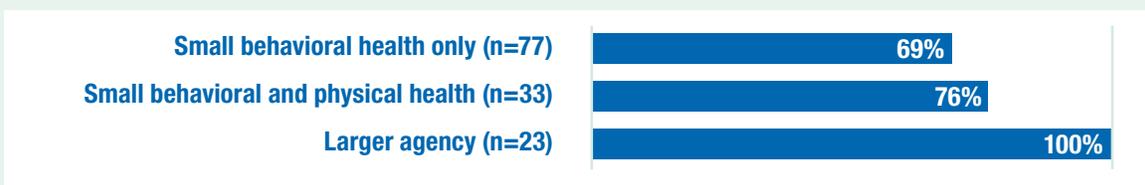
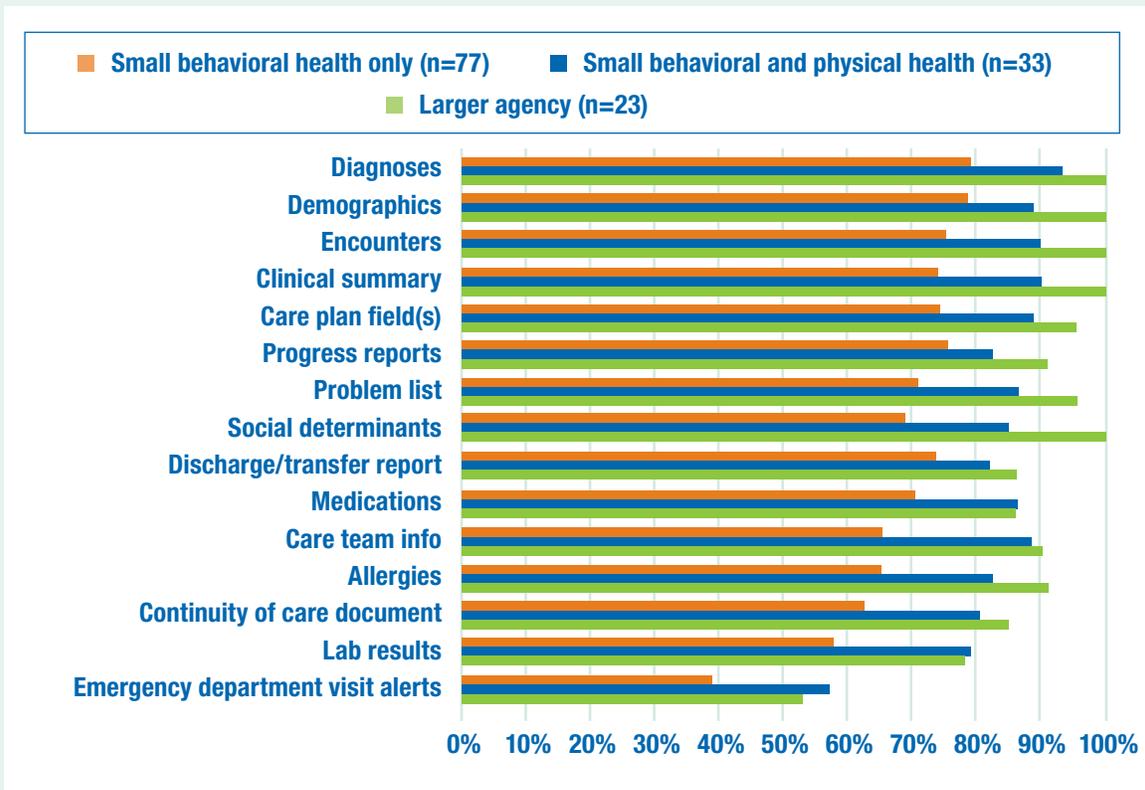


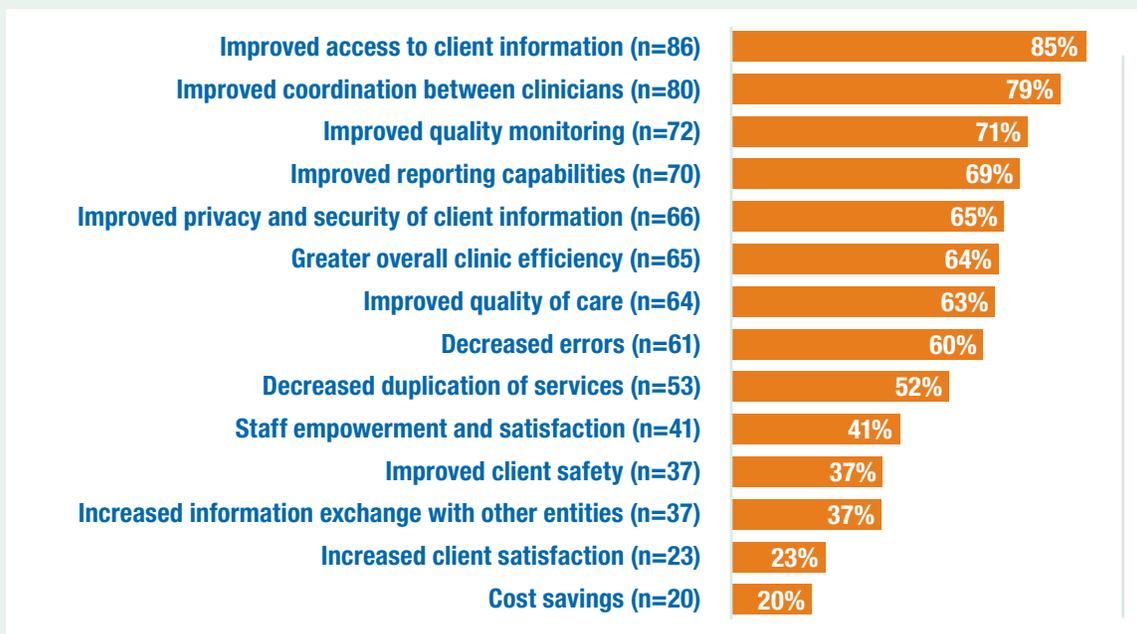
Figure 16: Type of data captured electronically by agency size and whether provides physical health services (N=133)



EHR benefits experienced by those with an EHR

Agencies with an EHR were asked about the benefits of their EHR use. Most agencies reported several improvements including access to client information, coordination between clinicians, quality monitoring, reporting capabilities, privacy/security of client information, clinic efficiency and quality of care. Only approximately one-third noted they had experienced increased information exchange with other entities.

Figure 17: EHR benefits (N=101)

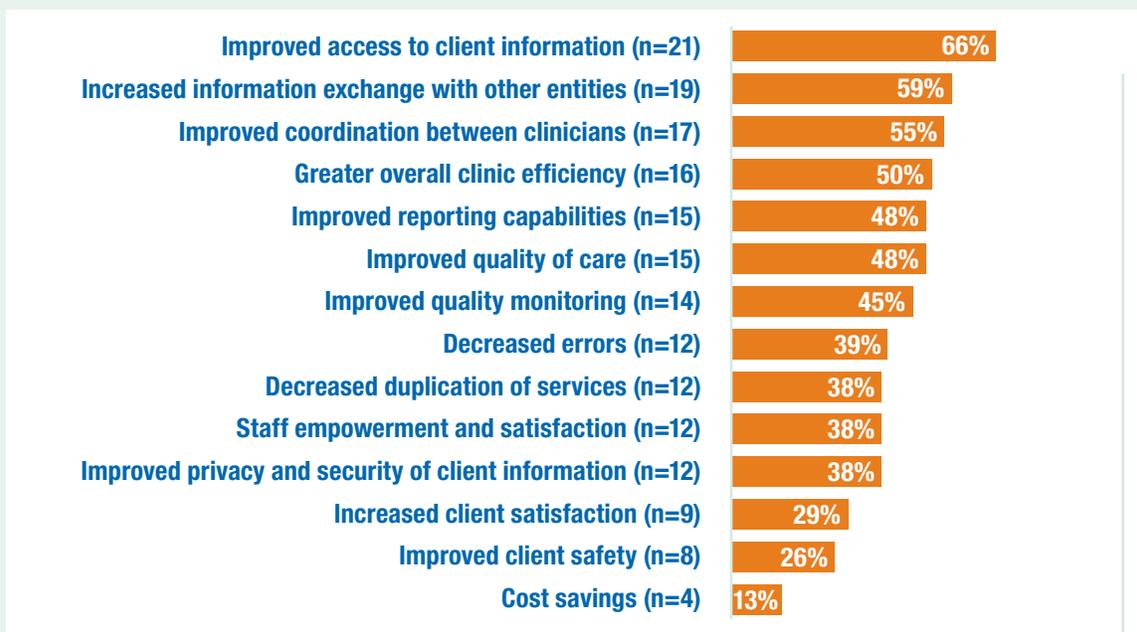


Note: n's (e.g., n=86) represent the number of respondents who provided a response.

Expected benefits of EHR adoption by agencies without an EHR

The survey asked agencies that reported not using an EHR about anticipated benefits of EHR adoption. Two-thirds reported that they expect improved access to client information. Many (59%) expect to experience increased information exchange, although this is reported as one of the top challenges amongst those who have adopted an EHR (see below). Not surprisingly, cost savings was recognized as having the least amount of potential benefit.

Figure 18: Potential benefits for those without an EHR (N=32)



Note: n's (e.g., n=21) represent the number of respondents who provided a response.

EHR satisfaction, challenges and barriers

The survey asked agencies with an EHR about their level of satisfaction with their current EHR and the challenges they have experienced. Approximately two-thirds of the agencies that adopted an EHR are somewhat or very satisfied with their EHR and approximately one-quarter reported being somewhat or very unsatisfied. Financial costs were listed as a top challenge for agencies with an EHR.

Figure 19: Agencies with EHRs satisfaction with EHR (N=101)

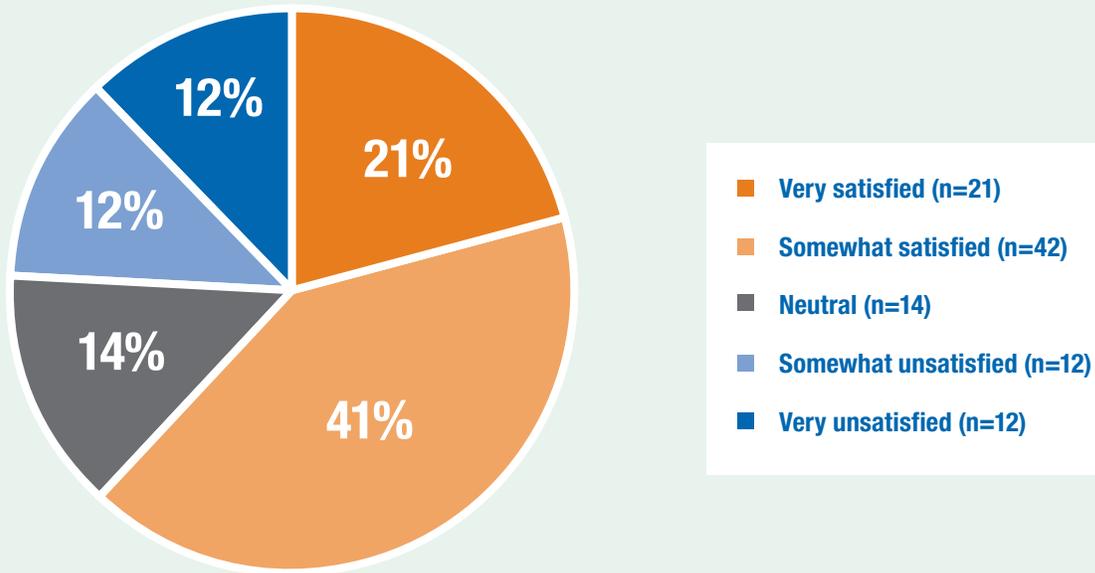
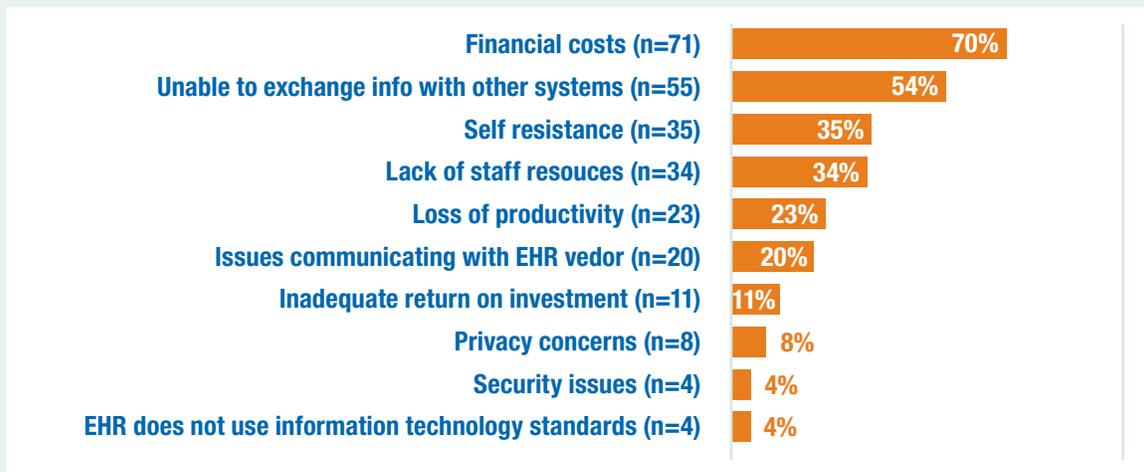


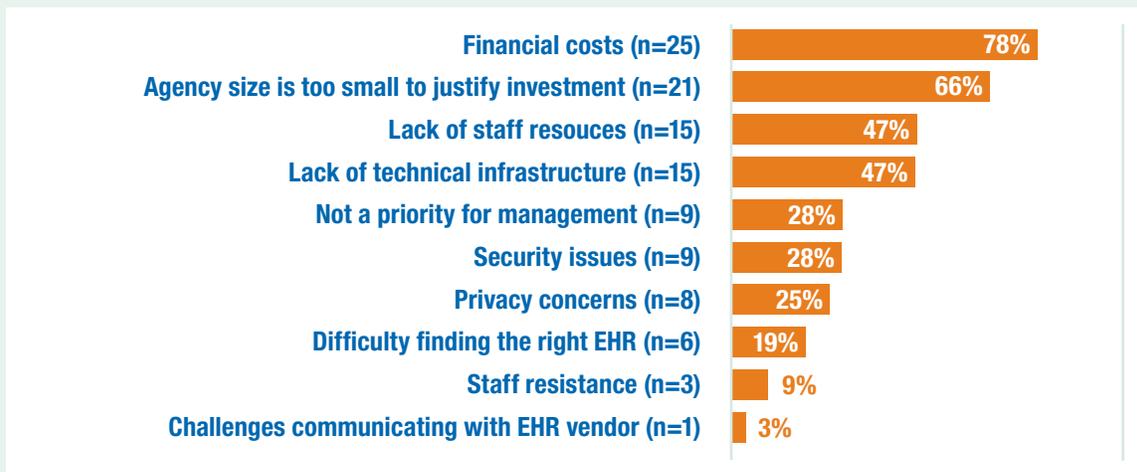
Figure 20: EHR challenges for those who have an EHR (N=101)



Note: n's (e.g., n=71) represent the number of respondents who provided a response.

The survey asked agencies without an EHR about barriers to EHR adoption. Similar to agencies with an EHR, those without also reported financial cost as the top barrier. Other reported barriers include the agency being too small to justify the investment as well as lack of staff resources and technical.

Figure 21: Barriers for those who do not have an EHR (N=32)



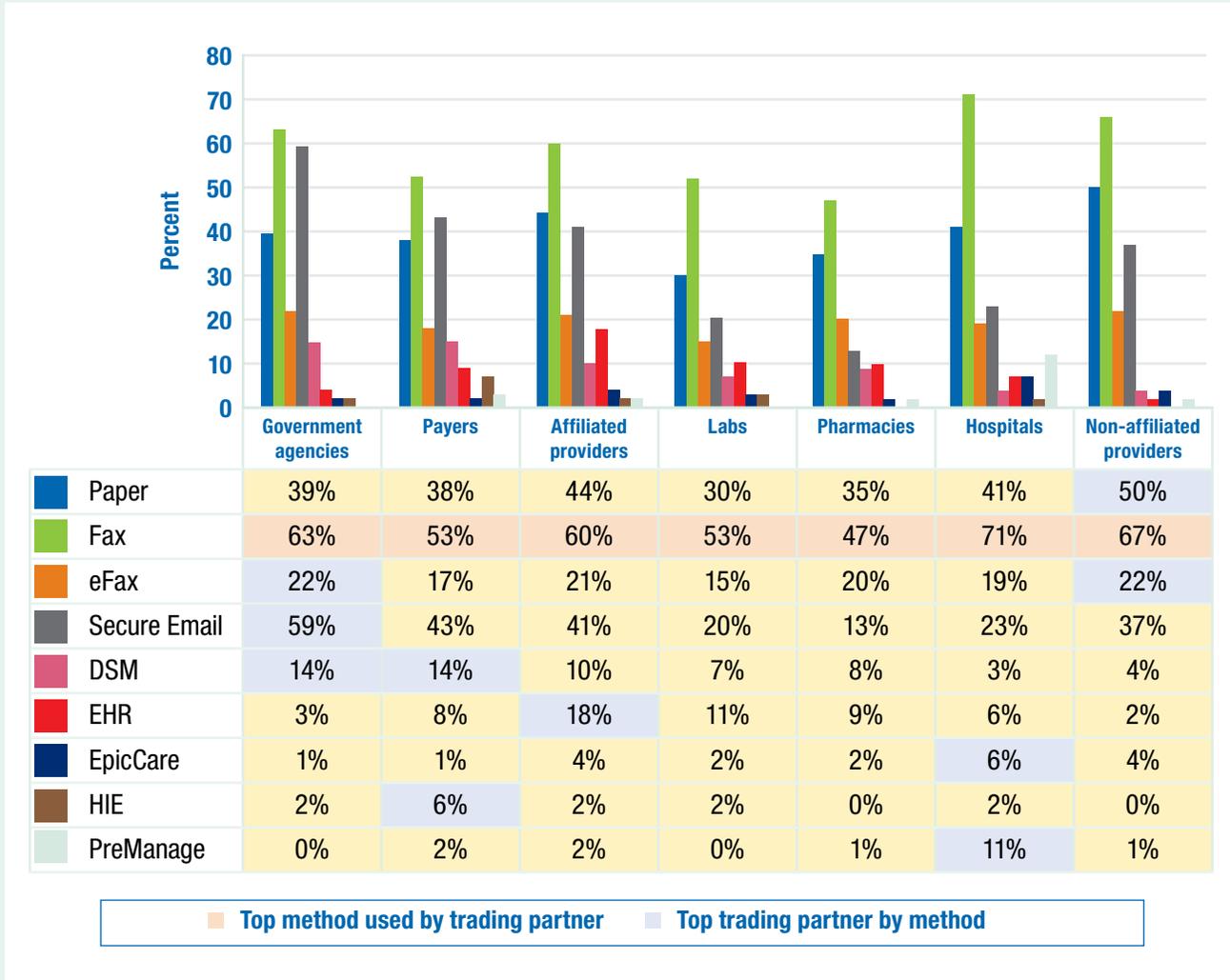
Note: n's (e.g., n=25) represent the number of respondents who provided a response.

Health information exchange

Methods used to share information by trading partner

Agencies reported on the information sharing methods they use with various entities. The figure below shows the patterns of use for each method across entity types. For example, the highest percentage of behavioral health agencies reported using secure email when exchanging information with government agencies (59%); the lowest percentage reported using secure email with pharmacies (13%). However, the highest percentage of agencies reported using fax when exchanging information with hospitals (71%) and the lowest percentage reported using fax to exchange information with pharmacies (47%).

Figure 22: Methods used to exchange information by trading partner (N=133)



Interest in electronic information exchange via an HIE

The survey asked agencies if they would be interested in accessing and/or sharing information via services provided by a regional or private health information exchange (HIE).

Information might include closed-loop referrals, results delivery, and a community health record (accessible via web portal or EHR integration). Survey respondents expressed a strong interest in both accessing and sharing client information using an HIE.

Figure 23: Interest in accessing client info via an HIE (N=96)

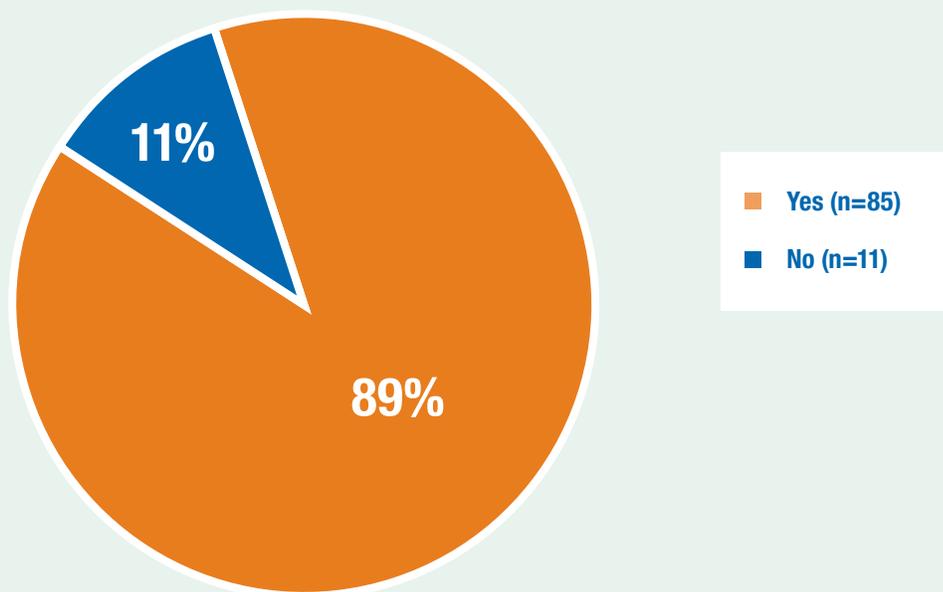
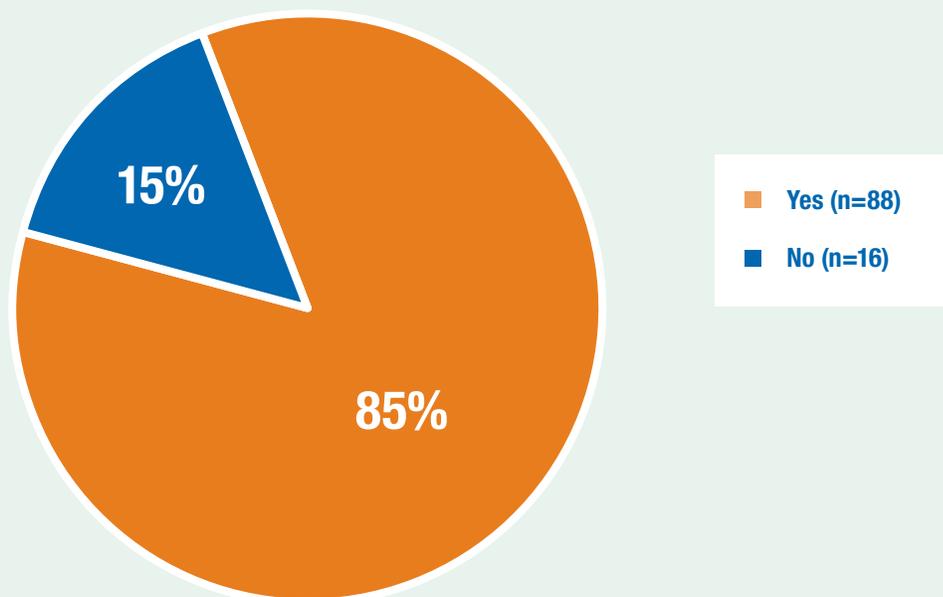


Figure 24: Interest in sharing client info via an HIE (N=104)



Note: Sample sizes vary due to “don’t know” responses and non-responses.

Sub-analyses: Program type(s): Substance use disorder, mental health or both

Agencies that provide both SUD and mental health treatment almost universally share more data electronically. Mental health-only agencies share less data with SUD programs but otherwise tend to share data more frequently than SUD-only agencies. Agencies providing both SUD and mental health treatment use more robust electronic exchange methods than those providing just one type of service.

Figure 25: Frequent need to share data by trading partner (N=133)

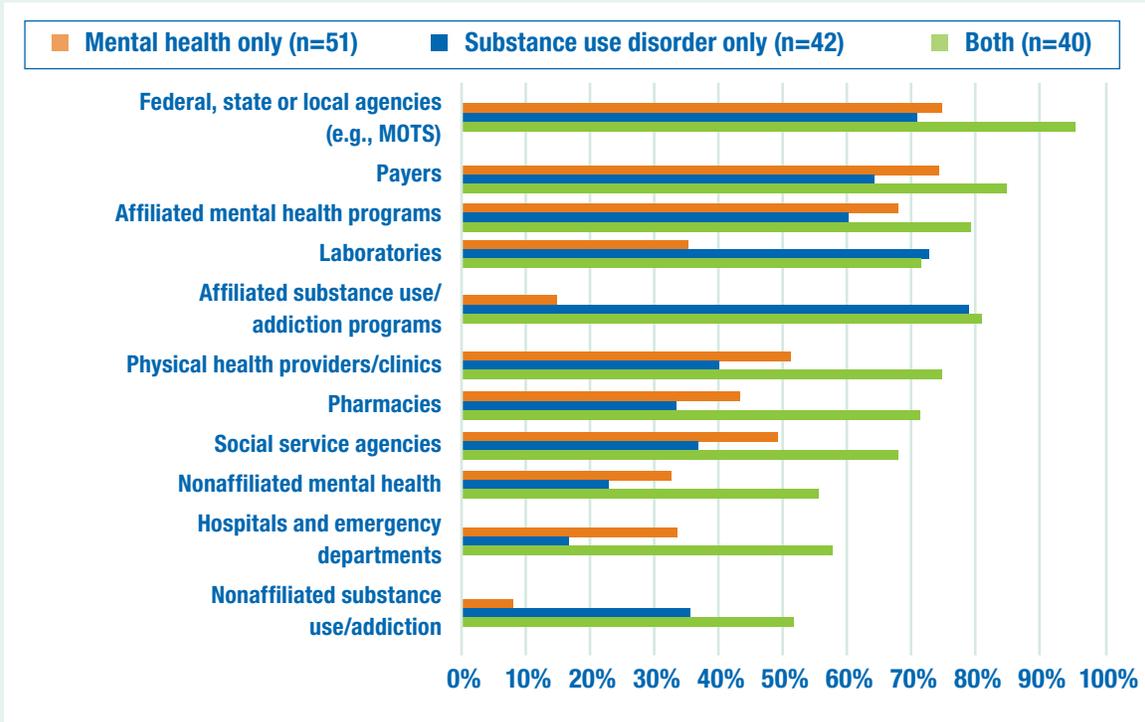
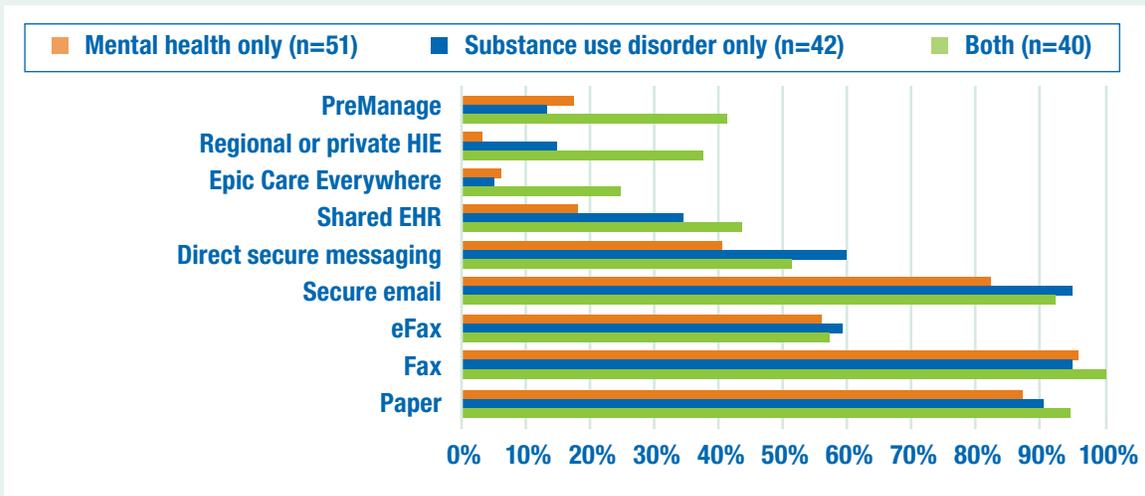


Figure 26: Methods used for information exchange (N=133)



Sub-analyses: Agencies with physical health services

Part of larger physical health organization

Those agencies that are part of larger organizations providing physical health in addition to behavioral health services share data more frequently and robustly.

Figure 27: Frequent need to share data by trading partner (N=133)

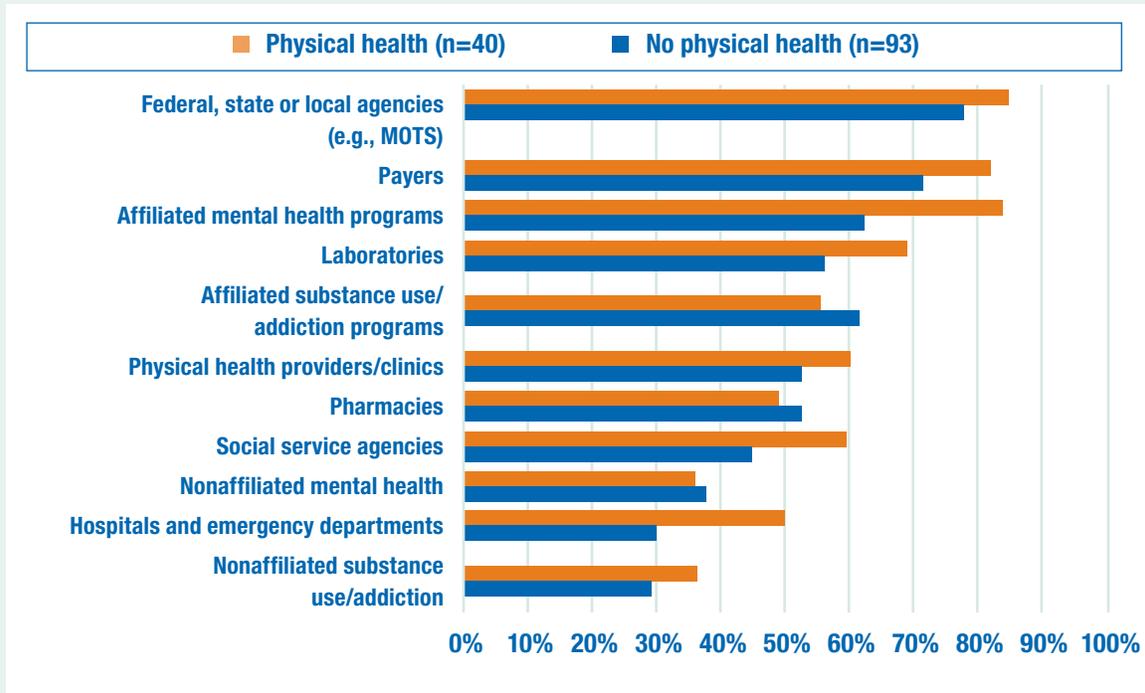
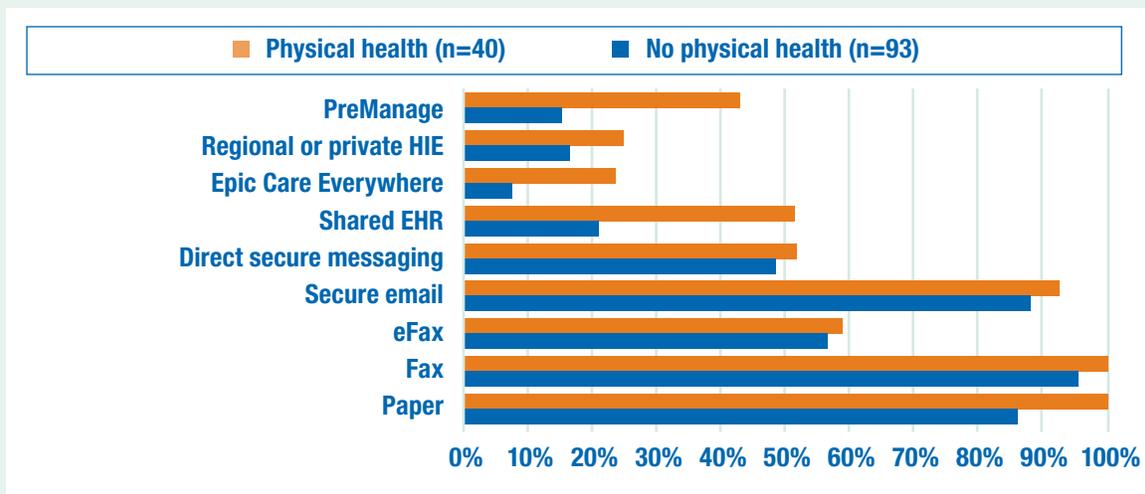


Figure 28: Methods used for information exchange (N=133)



Sub-analyses: Agency size and physical health services

Small, standalone behavioral health agencies (those with between one and five licensed behavioral health programs) have lower rates and less robust methods of information sharing than small behavioral health agencies within a physical health agency or larger agencies (those with six or more licensed programs) regardless of whether they provide physical health. Large agencies share data most often, though not necessarily through more robust methods besides PreManage.

Figure 29: Frequent need to share by trading partner (N=133)

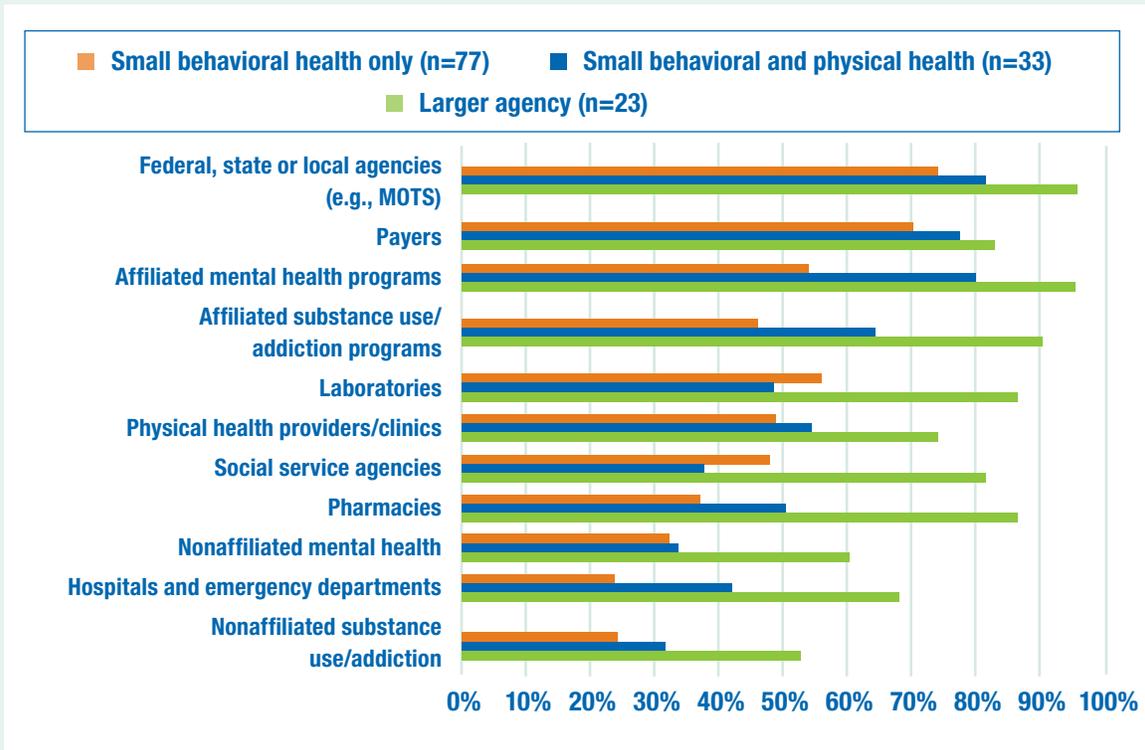
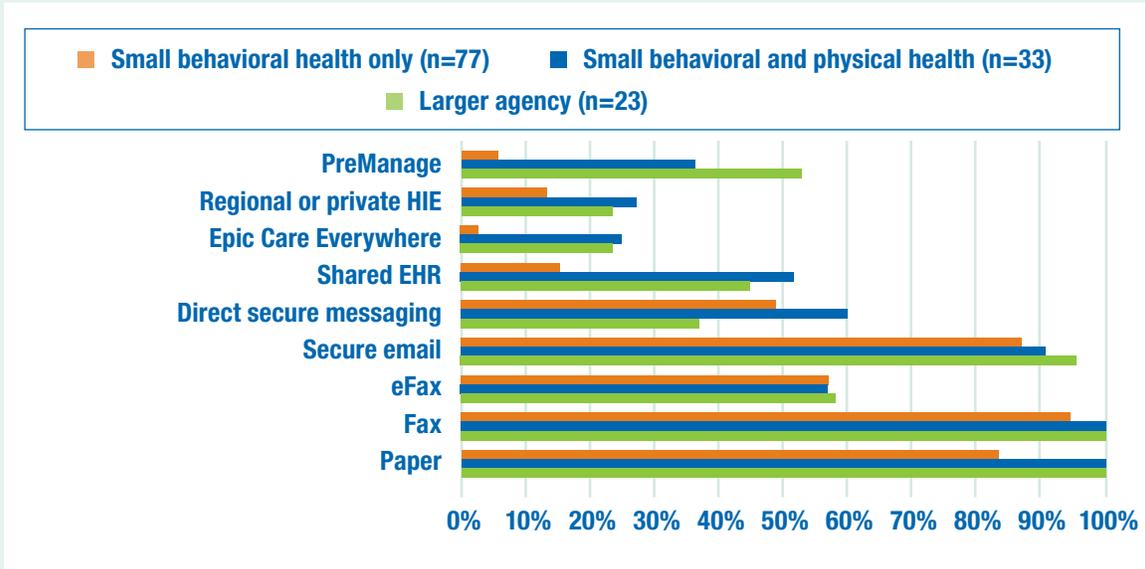


Figure 30: Methods used for information exchange (N=133)

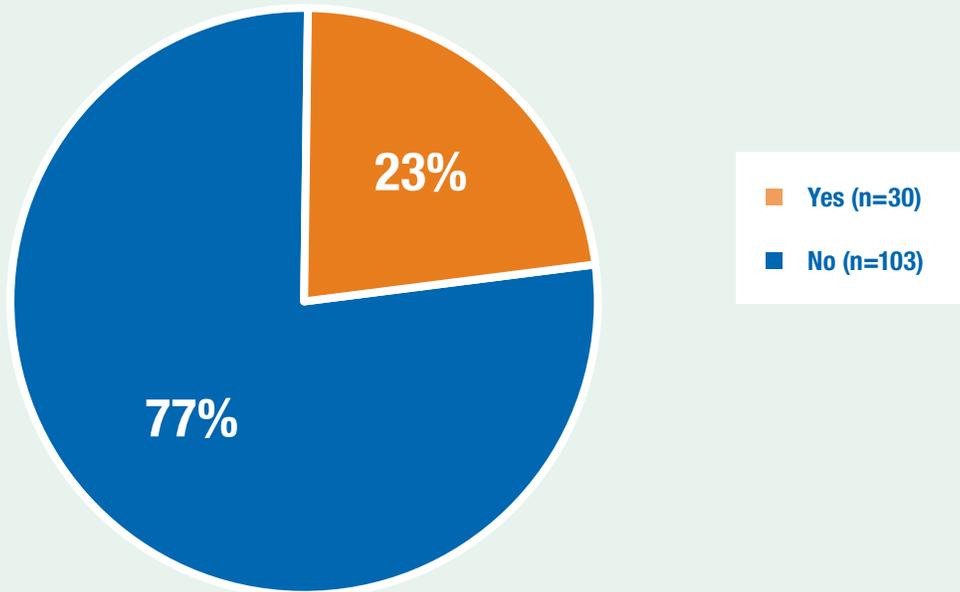


Use of electronic means to engage and interact with clients

Patient portal and electronic access

Agencies noted the ways in which they might be using HIT to engage their clients, and any benefits and/or barriers they had experienced with such engagement. Client access to their information has the potential to increase engagement in their treatment and lead to better outcomes. However, behavioral health agencies do not widely offer patient portals or other electronic access to health information. Only 23% of respondents offer patient portals and 39% offer electronic access of any kind. Computer literacy challenges, lack of client interest and lack of portal access were identified as the top barriers for electronic access.

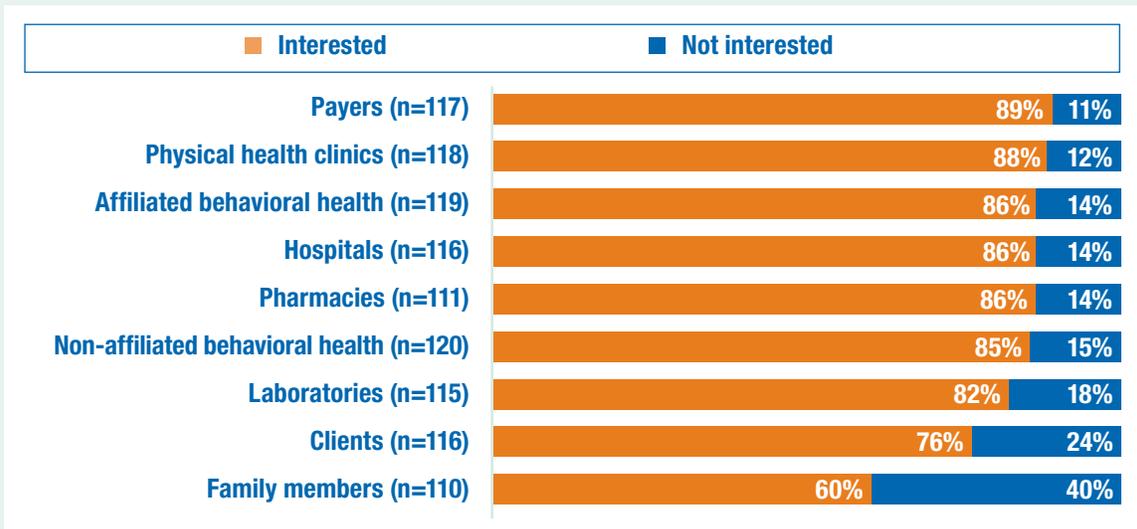
Figure 31: Patient portal access (N=133)



Interest in electronic exchange with clients and family members

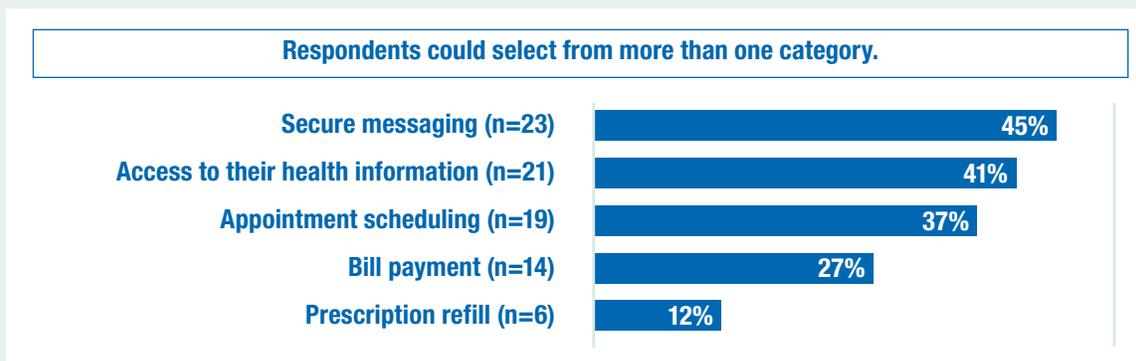
Agencies replied about their interest in establishing or expanding electronic information exchange capability with various entity types. They reported significant interest in electronically exchanging information across entity types, including with clients and family members; although only 23% of agencies reported having a patient portal, 76% expressed interest in client access and 60% in family members having access.

Figure 32: Interest in electronic exchange by entity type (N=133)



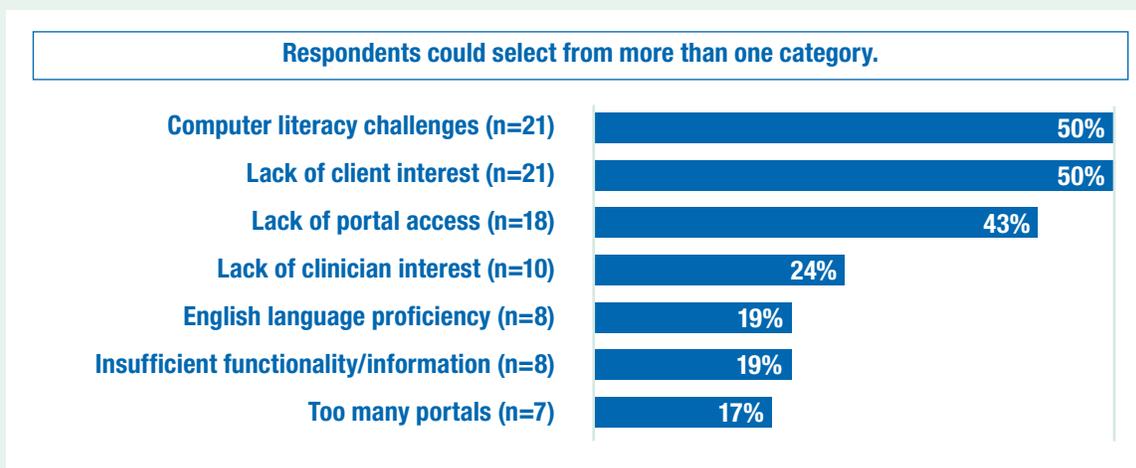
Note: n's (e.g., n=117) represent the number of respondents who provided a response.

Figure 33: Electronic access available to clients (N=51)



Note: n's (e.g., n=23) represent the number of respondents who provided a response.

Figure 34: Barriers to electronic access (N=42)

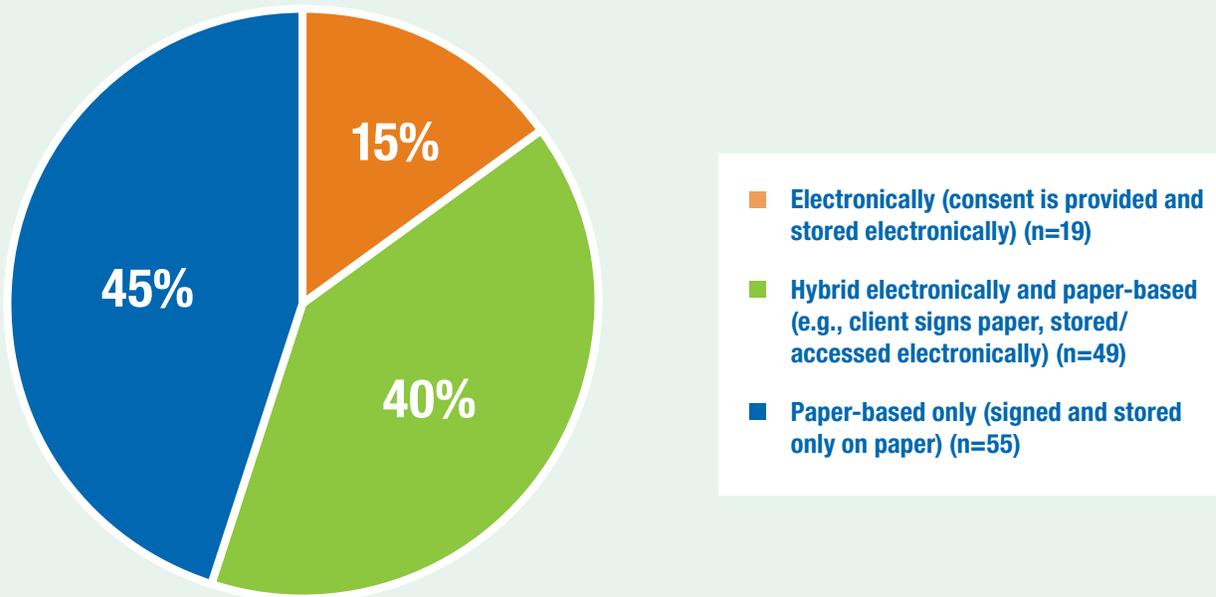


Note: n's (e.g., n=21) represent the number of respondents who provided a response.

Release of information process

Agencies were asked about their release of information process. Nearly half reported using a paper-based only process, while 15% reported using an electronic process; 40% use a hybrid process.

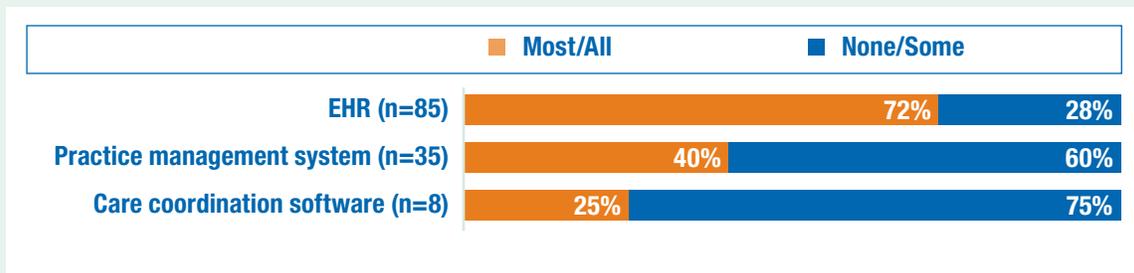
Figure 35: Method used for release of information (N=123)



Reporting and Measures and Outcomes Tracking System (MOTS)

Agencies were asked about which of their electronic systems capture information needed for reporting and the process by which they submit required information to OHA's Measures and Outcomes Tracking System (MOTS). Capturing and storing electronic information can facilitate required reporting. Approximately two-thirds of respondents reported that EHRs capture most or all in the information needed for MOTS.

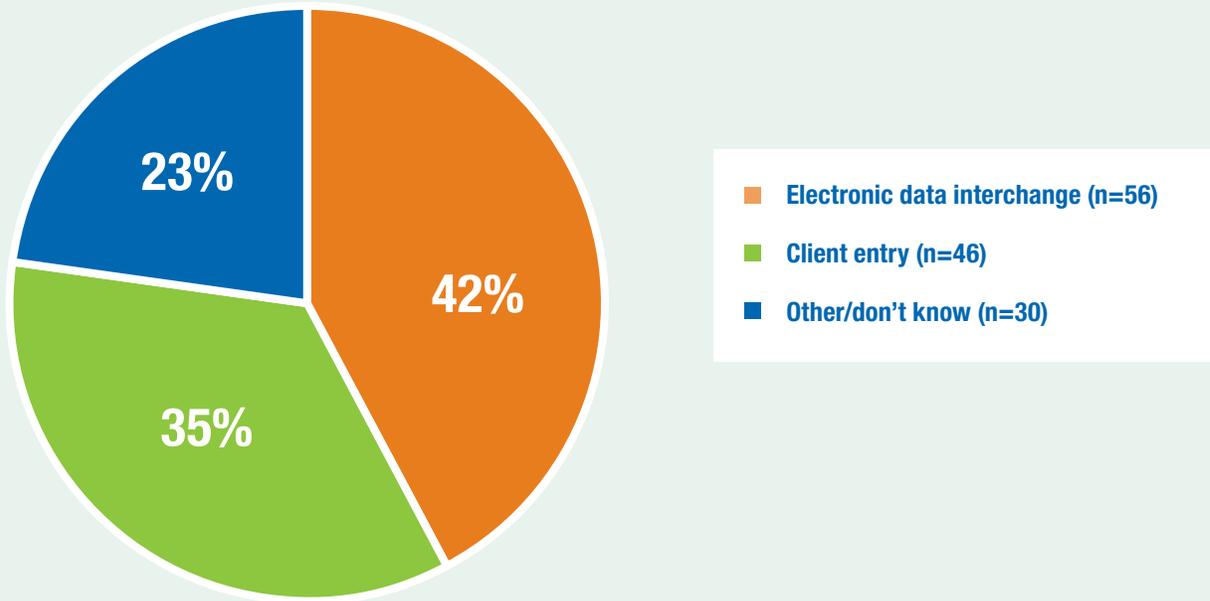
Figure 36: Systems used to capture reporting information (N=128)



Note: n's (e.g., n=85) represent the number of respondents who provided a response.

More than one-third (42%) of the agencies reported submitting required information to MOTS via Electronic data interchange (EDI). There were 29 EHR users who submit data to MOTS via client entry and not EDI. These users were asked why they did not submit electronically. Almost half (45%) reported that the EHR does not capture the required information; 34% reported that their EHR does not support EDI connectivity while 31% did not have the financial resources for the EHR vendor to develop the EDI capability.

Figure 37: Method used for MOTS submission (N=132)



Appendix E

Summary of in-depth interviews

Overview

This document is an addendum to the “Behavioral Health HIT Report.” It follows the structure of the results, conclusions and recommendations put forth in the report. This summary provides an overview of the in-depth interview process, followed by a narrative description of relevant interview themes and highlights. Tallies of themes and highlights appear throughout, some within relevant sections and others (that do not discretely fit into the identified needs) are at the end of this document.

In-depth interviews: Methodology and respondent characteristics

Based on information collected via survey, a sample of 22 agencies representing various agency characteristics was identified and invited to participate in a follow-up phone interview. The agencies had all self-identified in their survey response as willing to be contacted for a follow-up interview. Further, staff selected agencies for interviews to ensure broad representation across various characteristics:

- Number of programs administered
- Geographic location(s)
- Population density of the geographic location(s) of the behavioral health program(s)
- Characteristics of population served (Native Americans and tribal, racially and ethnically diverse, justice-involved, children and youth vs. adults, etc.)
- Affiliated with/part of a larger organization that provides physical health services
- EHR implementation status, vendor, satisfaction and duration of use
- Willingness to engage with HIE

OHA completed in-depth interviews with 12 agencies. Although the respondents represented a broad range of characteristics (see tables below), we were not able to interview an agency with no EHR.

Interviewees were exceptionally engaged, eager to discuss their experiences with HIT/HIE, often willing to spend additional time providing helpful and pertinent details about their agency’s approach to and use of information technology tools. OHA learned a great deal through these conversations, which helped deepen our understanding of the challenges and needs faced by behavioral health agencies, providers, patients and tribal governments. This

rich contextual information supplemented the survey results and will help inform OHA’s approach to supporting the transformation of the behavioral health system.

Table 1. In-depth interview invitee/interviewee sample characteristics

Agency size	Agencies invited	Agencies participated
Small (1–5 programs)	15	8
Medium (6–10 programs)	5	3
Large (11+ programs)	2	1
Total	22	12

Types of programs offered*	Agencies invited	Agencies participated
Outpatient A&D	18	10
Outpatient mental health	11	6
A&D residential	3	1
Adult mental health residential	6	4
Intensive treatment services	2	1

Population density: Agency has programs in:	Agencies invited	Agencies participated
Urban area(s) only	12	6
Rural area(s) only	10	7
Frontier area(s) only	4	2
Urban and rural area(s)	3	2

Other agency characteristics	Agencies invited	Agencies participated
Tribal	4	3
Corrections	1	1
Provide child services	3	3
Equity-focused	3	1
Physical health affiliated	11	8
EHR in use	19	12
No EHR in use	3	0

Interview limitations. Interviewers used a semi-structured interview format to maximize the engagement and discussion of relevant topics. Inherent in this format is that not all interviewees answered the same set of questions, discussed the same topics, or provided OHA with the same information. The interviewers encouraged discussion of HIT/HIE topics of

* Agencies can offer more than one type of program.

greatest relevance and importance to each agency. Therefore, theme and highlights included in this summary represent the most top-of-mind HIT/HIE topics. Thus, if an agency did not discuss a topic, it may still be relevant but did not come up in the interview.

Behavioral health agency in-depth interviews: Themes and highlights

The themes and highlights are organized into five sections; the first four mirror the key results in the “Behavioral Health HIT Report” (i.e., HIT/EHR, HIE, privacy/security, and data analytics/reporting) and the last section includes other themes (e.g., benefit of HIT to clients, telehealth, sharing best practices/TA) that were raised in addition to the topics in the key results.

Key result 1: Most behavioral health agencies are investing in HIT. However, the systems are often insufficient to adequately support the full spectrum of behavioral health’s HIT/HIE needs.

Result 1a. Nearly one-quarter of agencies do not have an EHR; they tend to be smaller and face greater resource barriers.

Result 1b. Behavioral health agencies are electronically capturing a broad array of information critical to care coordination and integrated care. However, many of the systems are unable to capture all needed data and/or lack critical capabilities for processing and meaningfully using stored information.

Conclusion 1: Most behavioral health agencies could benefit from additional HIT support.

- **Need 1a:** Robust HIT tools available in the marketplace that serve behavioral health-specific needs.
- **Need 1b:** Financial support and technical assistance for EHR adoption, implementation, maintenance or upgrade.
- **Need 1c:** Opportunities for collaboration and shared learning around EHR adoption.

Three major themes emerged from the interviews related to HIT investments and EHRs. A first major theme of the interviews was that EHRs provide good value, especially when they handle billing functions and help agencies better understand workload, outcomes and opportunities for improvement. All agencies expressed being fully committed to their EHR investment and showed a strong interest in increasing use of HIT to provide better care and increase efficiency. However, they also communicated barriers and challenges to greater HIT investment and use.

Interview themes aligning with key result 1: HIT/EHR	Total # agencies that mentioned theme (n=12)	Size			Population density			Other		
		Small agency (n=8)	Medium (n=3)	Large (n=1)	Frontier (n=2)	Rural (n=7)	Urban (n=6)	R/U combo (n=2)	Tribal (n=3)	Physical health combo (n=8)
Theme 1: EHRs provide good value										
BH providers think EHRs provide good value.	11	7	3	1	2	6	6	2	3	8
EHRs can make billing easier, which helps justify the cost.	3	1	1	1		1	2			2
BH agencies without in-house IT staff struggle to keep up with HIT.	2	2				1	1			

Note: Orange cells have 100% of respondents in that category.

A second major theme was the challenge of the **financial costs associated with their EHRs**. In addition to the expected implementation and maintenance costs, many behavioral health agencies manage multiple grant- or contract-supported programs that require regular EHR modifications as program requirements for data tracking change, which increases maintenance costs. Behavioral health providers often cannot afford more robust EHRs, and smaller vendors may be less able/willing to meet customization needs at an affordable cost. One agency reported their vendor required a \$1,000 payment, on top of an hourly fee, to merely provide a quote for needed customizations to meet grant requirements. A sub-theme emerged regarding agency approaches to dealing with the challenge of financial costs. A few agencies reported various **informal efforts to manage EHR costs**, such as bulk purchases with other behavioral health agencies, “cloning” another agency’s EHR instance (with vendor approval) and being an additional user for another agency’s EHR.

Interview themes aligning with key result 1: HIT/EHR	Total # agencies that mentioned theme (n=12)	Size			Population density			Other		
		Small agency (n=8)	Medium (n=3)	Large (n=1)	Frontier (n=2)	Rural (n=7)	Urban (n=6)	R/U combo (n=2)	Tribal (n=3)	Physical health combo (n=8)
Theme 2: Financial costs of EHRs are a challenge										
Agencies need financial support for EHR adoption and maintenance (including changes when program requirements change, which is driven by funders and laws/regulations); one noted problems faced by smaller counties with fewer resources, as opposed to more well-resourced counties.	3	2	1			1	2			1
Agencies received EHR Incentive Program payments; agencies that have physical health programs may get indirect benefits.	4	3	1		1	3	1	1	2	4
Theme 2a: Approaches used to manage financial costs										
BH providers have created/joined informal collaborations to fill gaps related to financial support, technical assistance around adoption/implementation. These services have partially met their needs.	5	2	2	1	1	2	2		1	4
Providers may share EHRs with other clinics to reduce costs.	2	1	1		1	1	2	1		1
Non-financial resources needed for EHR adoption would be helpful. Respondents specifically mentioned legal advice; discussions with clinicians, partners and peers who have adopted EHRs; tech support; IT staff; provider training; IT infrastructure; and user communities for certain EHR products.	9	5	3	1	2	5	3	1	3	8

Note: Orange cells have 100% of respondents in that category.

The third major theme expressed related to the capabilities and the **need to customize their EHRs** to meet their needs – it is challenging for them to use an EHR “off the shelf.” Behavioral health agencies support a diverse set of programs and services offered (e.g., mental health or substance use only vs both), requiring different EHR functionality for safeguarding protected information. Some agencies offer additional social service supports requiring the tracking and management of different data. Interviewees reported that many EHRs offering functionalities of interest are designed for physical health entities that track different information, have different workflows and require different reporting capabilities.

Many interviewees discussed EHR limitations related to using stored information for reporting purposes. In addition, interviewees noted their IT systems are not meeting their practice management needs (e.g., the need to track administrative issues such as caseload size and efficiency, show-up rates, and program-specific data elements required for grant or contract reporting).

“ As much as we pay for it, plus our system support costs, I could hire another physician.”

“ A lot of what we do is customize it [our EHR] to fit a square peg in a round hole.”

“ We [clinicians with no technical background] need IT staff who speak our language.”

“ Getting an EHR as comprehensive as we need is challenging ...”

IS YOUR EHR A SIGNIFICANT FINANCIAL BURDEN?

“ It’s a significant financial investment ... I wouldn’t call it a burden.”

“ If you want a system to function correctly, it needs a lot of maintenance ... You need somebody with expertise ... to be monitoring it and maintaining it.”

Interview themes aligning with key result 1: HIT/EHR	Total # agencies that mentioned theme (n=12)	Size			Population density			Other		
		Small agency (n=8)	Medium (n=3)	Large (n=1)	Frontier (n=2)	Rural (n=7)	Urban (n=6)	R/U combo (n=2)	Tribal (n=3)	Physical health combo (n=8)
Theme 3: EHR customization needs										
BH providers want to expand the functions of their EHRs.	11	8	2	1	1	7	6	2	3	7
BH providers need EHRs that are more centered on BH needs (e.g., workflow, program-specific information tracking and items like caseload management).	3	2		1		2	1		2	3
Many BH providers are non-profits and cannot afford the most robust EHRs. They must use smaller vendors, who may be less able to customize to BH needs.	3	2		1		2	1		1	2
Many BH providers are managing multiple grant-based programs with very specific information requirements. They need more EHR customization than physical health because each grant program can be different. Changing reporting requirements can make it very difficult to keep up.	2	1		1			2			1
BH providers feel they have been left behind in the push to adopt HIT, including funding opportunities and products designed around their needs.	2	1		1		1	1			1
Some providers have outdated EHRs that are no longer meeting their needs.	2	1	1			1	1		1	2
Some providers must do double entry to make use of EHRs	2	1		1			2			1
Doing data tracking required for grants and CCOs would require three additional FTE if the EHR was unable to track it.	1	1			1					1
Biggest challenges include the extraction of information out of the EHR for reporting, as well as setting up the EHR to capture the important information.	1		1		1					1

Note: Orange cells have 100% of respondents in that category.

Key result 2: Most behavioral health agencies have a need to exchange information with other entities; however, few are doing so using modern electronic methods.

Result 2a. Behavioral health agencies reported that all types of patient information is important for exchange.

Result 2b. Behavioral health agencies are currently exchanging Information mostly via fax, paper, secure email, eFax and Direct secure messaging, influenced by the HIE capabilities of information trading partners.

Result 2c. Almost all respondents reported an interest in expanding their ability to exchange information electronically with a wide array of trading partners.

Conclusion 2: Behavioral health agencies need HIE opportunities, which are evolving.

- **Need 2a:** HIE tools that can serve behavioral health-specific needs. This includes the ability to exchange information with priority information trading partners, including social determinants of health partners.
- **Need 2b:** Financial support and technical assistance for HIE participation.
- **Need 2c:** Robust HIT to support participation in health information exchange.

Two major themes emerged related to electronic health information exchange. The first was a **need for HIE tools to exchange information with range of trading partners**, including those providing social determinants of health services and support. Every agency interviewed reported a need to exchange health data and most identified a range of at least four information trading partners (if not many more). This includes partners whose work affects the social determinants of health. All interviewees confirmed the finding that much of the information exchange is still done via fax. One said, “Our HIE is ‘faxing.’”

Another agency, with a relatively robust EHR, noted that the technical capabilities of the least technologically advanced trading partner tend to drive the method of exchange.

Multiple interviewees stated that the currently necessary reliance on faxing decreases speed and efficiency. Two interviewees also raised the issue of privacy concerns caused by faxing and paper document exchange.

A second major theme arose on the topic of health information exchange. Respondents weighed in on what **resources and support are needed to implement and us HIE**. For example, there is a need for assistance to remove various barriers to electronically sharing and exchanging health information, including financial support and education.

“ Paper has more opportunities [than EHRs] for breaches of privacy. Faxing is just as bad – you never know who is standing at the other end. ”

“ I’m sort of amazed that we still do as much faxing as we do today, because it’s such an old technology, but everyone asks for a fax. ”

Interview themes aligning with key result 2: HIE	Total # agencies that mentioned theme (n=12)	Size			Population density			Other		
		Small agency (n=8)	Medium (n=3)	Large (n=1)	Frontier (n=2)	Rural (n=7)	Urban (n=6)	R/U combo (n=2)	Tribal (n=3)	Physical health combo (n=8)
Theme 1: HIE tools needed to exchange information with range of trading partners										
All agencies need to share information with outside trading partners.	12	8	3		2	7	6	2	3	8
Most use fax as a primary means of information sharing (but may not be the only primary method of sharing).	11	8	2	1	2	7	6	2	3	7
Having the opportunity to communicate with SDOH partners is important for BH providers. We need to establish and prioritize an effective means to exchange this information.	7	6	1			4	2	1	3	4
Some providers had joined a regional HIE or were in process of joining; one said it was not helpful because their trading partners were not connected.	3	2	1		1	1		1	1	2
BH providers are interested in information about ED admissions.	3	2		1		1	2		1	2
Agencies have trading partners statewide.	2	2				1		1	1	1

Interview themes aligning with key result 2: HIE	Total # agencies that mentioned theme (n=12)	Size			Population density			Other		
		Small agency (n=8)	Medium (n=3)	Large (n=1)	Frontier (n=2)	Rural (n=7)	Urban (n=6)	R/U combo (n=2)	Tribal (n=3)	Physical health combo (n=8)
Theme 2: Support needed for HIE implementation and use										
Most did not know much about HIE opportunities and wanted to learn more.	8	6	1	1	1	3	2	2	2	4
Critical mass issue—even those that can use electronic means may not have trading partners that can do so.	2	1		1	1		1			2
Agencies need financial support for HIE adoption.	2	1	1		1		1			2
There are challenges for tribes around trust and data privacy with HIE participation. (This is not limited to tribes. It reflects a top reported concern regarding HIE participation; see survey results.)	1	1				1			1	1

Note: Orange cells have 100% of respondents in that category.

Key result 3: In addition to resource barriers, privacy and security concerns are a top barrier to electronic information exchange.

Conclusion 3: Behavioral health stakeholders need more support and clarity about privacy and security of health information.

- **Need 3a:** Clear, consistent, reliable, actionable guidance about information sharing allowed under the law.
- **Need 3b:** Appropriate consent management tools and data segregation capability integrated into HIT/HIE products.

Many interviewees cited privacy and security concerns about sharing client information. Two major themes emerged related to privacy and security, including **the need for (1) tools and technical capabilities and (2) information and guidance to ensure compliance with laws and regulations.** Most agencies reported an awareness of and effort to manage information sharing according to known requirements. One-fourth of the agencies reported that, even when the client signed a consent form, some clinicians remain unwilling to share relevant information. This limits their ability to share relevant information with the rest of

the care team. One interviewee noted their agency has a concern that patients might be less likely to seek substance use disorder treatment if their primary care provider could access that information. However most, interviewees expressed the value and need for increased, less-restricted information flow to allow for improved care coordination.

Interview themes aligning with key result 3: privacy and security	Total # agencies that mentioned theme (n=12)	Size			Population density			Other		
		Small agency (n=8)	Medium (n=3)	Large (n=1)	Frontier (n=2)	Rural (n=7)	Urban (n=6)	R/U combo (n=2)	Tribal (n=3)	Physical health combo (n=8)
Theme 1: Tools and capabilities are needed to manage consent and data segregation										
Those with a variety of internal EHR users had some kind of internal controls (even if only need-to-know).	8	5	2	1	1	4	2	1	3	6
Agencies providing both physical and behavioral health services with a shared EHR allow behavioral health providers to see everything, but physical health cannot not automatically see behavioral health information.	4	3	1		1	3			3	4
EHR includes protocols to keep 42 CFR protected information secure.	2	2			1	1			1	2
Providers need financial resources (for EHR functionality) to deal with privacy issues.	1	1						1		
Theme 2: Need for information sharing guidance										
42 CFR part 2 inhibits sharing with physical health.	3	2		1		2	1		2	3
Agencies want better information about 42 CFR Part 2 to train staff.	3	1	1	1		1	2		1	3
Even when patients sign a release of information, providers don't want to share patient information.	3	2		1		2	1		2	3
Agencies interested in seeing regulatory changes to 42 CFR Part 2.	2	2				2			2	2
Agencies see faxing/paper records as a greater risk to privacy than ehr.	2	2			1	1			1	2
Agencies want better privacy protection to decrease paper floating around.	2	1		1	1		1			2
Some agencies are learning more about the security requirements of being paperless/using mobile technology.	1	1			1					1

Note: Orange cells have 100% of respondents in that category.

Key result 4: Data analytic tools and capabilities are necessary for improved patient care, reporting and practice management.

Conclusion 4: Behavioral health agencies could benefit from additional resources and support for data analytics.

- **Need 4a:** Robust HIT and access to critical data to support data analytics and reporting.
- **Need 4b:** Data analytics tools and capabilities that meet behavioral health specific needs.
- **Need 4c:** Streamlined/consolidated reporting requirements where possible to decrease burden.

Though not a topic included in the survey, during stakeholder interviews, most agencies discussed their need for data analytic capabilities to compile information for reporting (not only to the state, but also for reporting to satisfy various grant requirements), help them manage their client needs, and assist with business management.

Interviewees discussed using various approaches to data analytics, all of which were reported as being critical. Some interview participants described working with their vendors to build additional data capture and reporting capacity to support their needs. One (larger) agency reported pursuing additional data analytic support beyond its EHR’s capability, including a data warehouse and data analytics tool.

Interview themes aligning with key result 4: Data analytics and reporting	Total # agencies that mentioned theme (n=12)	Size			Population density			Other		
		Small agency (n=8)	Medium (n=3)	Large (n=1)	Frontier (n=2)	Rural (n=7)	Urban (n=6)	R/U combo (n=2)	Tribal (n=3)	Physical health combo (n=8)
EHRs are needed to support reporting.	8	4	2	1	2	2	2	1	2	6
Access to data is a priority.	6	3	2	1	1	1	2	2	1	4
EHRs are used for practice management (caseload size, clinician efficiency, patient show-up rates etc.).	6	4	1	1	1	1	2	2	1	4
EHRs are used or needed for patient care (tracking out-comes, identifying opportunities for better/more efficient care).	5	4		1	1	2	2	1	1	3
Agencies are creating own reports.	4	3		1		1	2	1	1	2
BH providers need time/flexibility to adapt to reporting changes; updating the EHR requires lead time, and if there’s not enough lead time, they are forced to track by hand, which drives up costs.	3	1	1	1	1		2			2

Note: Orange cells have 100% of respondents in that category.

Additional in-depth interview themes and highlights

In addition to the themes and highlights that align with the Key Results reported above, additional themes were raised as part of the in-depth Interviews.

Benefits of HIT to clients

Interviewees discussed various benefits of HIT to clients. Many of these themes are similar to those experienced by physical health providers. There is significant interest in providing clients with the means to electronically communicate with their agency's providers.

Additional interview themes: Benefits of HIT to clients	Total # agencies that mentioned theme (n=12)	Size			Population density			Other		
		Small agency (n=8)	Medium (n=3)	Large (n=1)	Frontier (n=2)	Rural (n=7)	Urban (n=6)	R/U combo (n=2)	Tribal (n=3)	Physical health combo (n=8)
Many providers are interested in electronic communication with patients (text reminders, patient portal, etc.) but are not yet fully engaged.	8	7	1		2	4	1	1	3	5
All providers said a significant portion of patient population can access at least some electronic communication (e.g., text appointment reminders) via cell phone.	5	4		1		3	2		2	3
Some have at least some electronic communication with patients now (occasional conventional email with informed consent, prescription refill portal with smartphone app, text reminders).	4	2	1	1		2	2		2	4
Better internal/external coordination of care is needed.	3	2	1				1	2		1
Two providers are doing collaborative therapy notes (therapist and client write the note together).	2	1	1		1			1		2
HIT creates less duplication of effort for patient.	1	1					1			
Billing aspect of EHRs can take financial stress off clients.	1	1				1				
HIT help providers be more organized when caring for clients.	1	1				1			1	1
HIT allows printing patient education information directly from EHR and sharing with clients.	1	1				1			1	1
HIT provides better continuity of care when there is high provider turnover.	1			1			1			1

Note: Orange cells have 100% of respondents in that category.

Telehealth

Some interviewees reported using telehealth, including telepsychiatry and teletherapy. One agency raised the concern that some providers are geographically isolated, which can affect many aspects of technology use to help provide care.

Additional interview themes: Telehealth	Total # agencies that mentioned theme (n=12)	Size			Population density			Other		
		Small agency (n=8)	Medium (n=3)	Large (n=1)	Frontier (n=2)	Rural (n=7)	Urban (n=6)	R/U combo (n=2)	Tribal (n=3)	Physical health combo (n=8)
BH providers are using telepsychiatry to help fill medication management gaps.	4	3	1		1	1		2	1	3
BH providers are using teletherapy.	2	1	1					2		1
Some BH providers are very isolated due to geography; broadband issues affect use of cloud-based EHRs, telepsychiatry, phone access and controlled substance prescriptions.	1	1			1					1

Note: Orange cells have 100% of respondents in that category.

Sharing best practices, technical assistance, communication

Interviewees expressed an interest in sharing best practices and increased communication about HIT/HIE successes and challenges. Also mentioned was an interest in greater visibility into the relevant HIT activities occurring at a state level as well as information collected by OHA.

Additional interview themes: Sharing best practices, technical assistance, communication	Total # agencies that mentioned theme (n=12)	Size			Population density			Other		
		Small agency (n=8)	Medium (n=3)	Large (n=1)	Frontier (n=2)	Rural (n=7)	Urban (n=6)	R/U combo (n=2)	Tribal (n=3)	Physical health combo (n=8)
BH providers need a way to share best practices with each other re EHR adoption/implementation.	4	4				3	1		2	2
BH providers need TA re EHR adoption (several mentioned not knowing what questions to ask).	3	2		1		1	2			1
BH providers need a way to share to share best practices with each other re HIE.	1	1				1			1	1
BH providers have Listserv/email group with whom to interact regarding challenges, successes, dissemination of info specific to BH HIT/HIE.	1		1				1			1
BH providers have statewide newsletter about what's happening in the state, who is connected to HIE, HIE successes, share best practices.	1	1				1			1	1

Note: Orange cells have 100% of respondents in that category.

Feedback to OHA

Interviewees provided OHA with feedback across various areas including MOTS, need/interest in increased/improved communication, concerns regarding duplicate reporting requests, and some confusion over state requirements.

Additional interview themes: feedback to OHA	Total # agencies that mentioned theme (n=12)	Size			Population density			Other		
		Small agency (n=8)	Medium (n=3)	Large (n=1)	Frontier (n=2)	Rural (n=7)	Urban (n=6)	R/U combo (n=2)	Tribal (n=3)	Physical health combo (n=8)
MOTS has been a challenging system with which to successfully interface; some are doing double entry.	3	1	2		1		1	1		2
Different state agencies require report of the same data.	1		1					1		1
It can be a challenge for counties to collaborate due to different interpretation of state requirements.	1	1						1		
There are many opportunities to improve communication and coordination between tribal clinics and state agencies.	1	1				1			1	1



HEALTH POLICY AND ANALYTICS DIVISION
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