

**Oregon Department of Human Services
Addictions and Mental Health Division (AMH)**

Behavioral Health Integration Project (B-HIP)

B-HIP Stakeholder's Meeting

February 8, 2007

8:30 am to 12:00 noon

Best Western Black Bear Inn

1600 Motor Ct NE

Salem, OR 97301-1801

MEETING MINUTES

WELCOME AND INTRODUCTION

Ben Kahn, B-HIP Project Director, welcomed the Stakeholder's Meeting participants and introduced the FOX System, Inc. team. Matt Bailey asked participants to introduce themselves. The list of meeting participants can be found in Attachment 1 of this document.

Matt reviewed the meeting goals, as follows:

1. B-HIP stakeholders will learn about the expanded B-HIP Project scope and progress of the Project to date.
2. B-HIP stakeholders will recommend modifications to the B-HIP Project Charter.
3. B-HIP stakeholders will learn about the current legislative funding request for the B-HIP Project.
4. B-HIP stakeholders will identify potential new B-HIP requirements.
5. B-HIP stakeholders will learn about and provide input into upcoming B-HIP related events.
6. At the end of this stakeholder's meeting, B-HIP stakeholders will be able to articulate information about the Project and be willing to provide on-going Project support.

COMBINED HOSPITAL AND COMMUNITY PROGRAM BUSINESS PLAN

Jarred Clark gave a presentation about the B-HIP Project (Attachment 2). Jarred spoke about the background of the Project and the current environment for reporting behavioral health addictions and mental health individual and service information to AMH. He highlighted the need for a new system from both a State hospital and community program viewpoint by discussing the internal and external problems and challenges. Jarred compared the current state to desired improvements, and spoke about the estimated cost of procuring and implementing the B-HIP system, as well as the projected Project Schedule. Information in the presentation was excerpted from the B-HIP Business Plan developed in May 2006.

B-HIP Guiding Principles

Ben outlined the seven Guiding Principles for B-HIP, including:

1. Single, integrated information system, capturing mental health and addiction services across the community and hospital environment, linking to other data systems.
2. Throughout the project, participation and collaboration from information trading partners will be included.
3. Focus on behavioral health system of care planning, implementation of Evidence Based Practices and recovery support monitoring, including ongoing analysis and evaluation of services.
4. Technical solution must address Addictions and Mental Health (AMH) individual and aggregate data needs well into the future.
5. Essential State and behavioral health service provider business functions drive the technical solution.
6. Meets Office of Information Systems (OIS) standards and industry best practices, which will result in a system acquisition from either public domain or commercial off-the-shelf sources, e.g. buy or transfer – not build.
7. Technology solution supports State and Department of Human Services (DHS) goals of increasing electronic commerce and transitioning to electronic media to improve data sharing, increase the amount of time providing services and improve clinical care.

B-HIP Description

Ben discussed the merging of the original B-HIP with the Hospital Management Information System (HMIS) project into a single Behavioral Health Integration Project (B-HIP) in the spring of 2006. The description of the new system is:

The Behavioral Health Integration Project (B-HIP) provides for the management and exchange of information across the continuum of behavioral health services provided to individuals through the Oregon State Hospitals, acute care hospitals and community-based service programs. B-HIP's comprehensive individual information will assist AMH and its service providers to improve service delivery and resulting outcomes for persons receiving behavioral health services in Oregon.

B-HIP Slogan and Benefits

Ben Kahn shared a new slogan for the project:

B-HIP – Integrating Treatment and Technology

Ben focused on the one-page handout about B-HIP located participants meeting packets that stakeholders can use to remind them about the benefits of the new B-HIP system when speaking about the Project (Attachment 3).

Ben brought participants up-to-date about Project activities over the past 2 years (Attachment 4), including:

- Joint Application Requirements (JAR) Sessions were held in July 2005 (focusing on behavioral health community program services) and April 2006 (focusing on State hospital services) to document the high level functional requirements for B-HIP.

- Functional requirements developed for community programs (Attachment 5) and State hospitals (Attachment 6) were compared and many similarities were discovered (Attachment 7).
- A Request for Information (RFI) was completed; received eleven (11) responses; produced an Alternatives Analysis Report to compare the B-HIP requirements with commercial off-the-shelf and public domain systems.
- Contacted potential software vendors for estimated cost information.
- Developed the B-HIP Business Plan justifying the need for new technology at the State hospitals and use of that technology in the community programs to collect and share data.
- Submitted a Policy Option Package (POP) to the Governor, who included it in his 2008-2010 biennial budget request to the Oregon State Legislature.
- Next steps include:
 - ✓ Working with the Oregon State Legislature to obtain Project funding.
 - ✓ Further analysis and documentation of the State Hospital business processes and functional requirements.
 - ✓ Implementing an educational awareness program about B-HIP.
 - ✓ Planning and holding a Vendor Fair.
 - ✓ Once funding is approved, developing and issuing a Request for Proposals (RFP) to procure and implement a B-HIP software solution.
 - ✓ Developing interfaces with other appropriate systems, e.g. Medicaid Management Information System (MMIS)

NEW B-HIP REQUIREMENTS

Matt Bailey randomly divided participants into five (5) working groups. Matt instructed the groups to review the macro-level requirements developed for the community programs (Attachment 5) and the State Hospitals (Attachment 6) and discuss within their group if there were additional requirements for B-HIP that needed to be included. Each group reported the results of their discussions.

New B-HIP Requirements identified included:

- **Homeless Status and Services, e.g. Housing**
 - ✓ Indicator or notes field needed
 - ✓ It's a continuity of care issue
 - ✓ Ability to record and maintain multiple iterations
 - ✓ Need the ability to track an individual's living situation over time
 - ✓ Need to know the types of housing that exist in the community and the availability of each; not all are licensed
 - ✓ Need B-HIP to collect information about who to contact to transition an individual to a different housing situation
 - ✓ Will need to standardize definitions
 - ✓ What happens to an individual and how it changes over time
- **National Patient Safety Goals**
 - ✓ JACHO requirements, e.g. medication variance/reconciliation (track prescribed medications vs. actual dosages taken)
- **Interface with law enforcement agencies**, county and city jails, Juvenile Justice and Courts, e.g. Traffic Safety, Justice Department, Department of Corrections, PSRB

- ✓ Need to know an individual's criminal history, e.g. the nature of any crimes committed, sexual crimes history
- ✓ Includes civil and criminal commitments
- ✓ It will be valuable to exchange information with courts and jails
- ✓ Need access to law enforcement data, e.g. DUII, Criminal Justice Commission, Juvenile Justice system
- ✓ Need ability to send secure and authorized records to the court system and have information come back into B-HIP from the courts
- ✓ PSRB data or interface with their data
 - The Governor's staff proposed B-HIP include PSRB data
 - AMH will engage PSRB personnel about their needs and integrate their data into B-HIP, if practical
- **Contact management needed in order to assure B-HIP has the flexibility to gather minimal data about an individual at first contact**
 - ✓ B-HIP needs to be flexible about required fields when engaging client into services – on cusp and don't want to overwhelm with lots of data
 - ✓ Collect minimum data initially, with a tickler system to eventually get data needed
 - ✓ Contact management was included in first JAR straw model, but participants removed it
- **Ready-to-Place list associated with OSH**
 - ✓ Different from waiting list
 - ✓ Track when an individual is ready for community placement and when they are actually placed
 - ✓ Once placed in the community, need to track length of stay, hospital re-admission (if applicable), details about the living situation, e.g. alone, independent, dependent
- **Incident management**
 - ✓ Need reporting of incidents from community programs

Additional ideas about B-HIP requirements generated by the groups included the following, listed in no particular order (already included in either State Hospital or community program requirements, or both):

- Track reasons why moved from OSH, as well as discharge barriers and length of stay in placement
- Interface with MMIS
 - ✓ MMIS is system of record for licensing of Medicaid providers
 - ✓ Need to access MMIS provider information, e.g. to know licensing and certification status about service providers, as programs lose licensing from time to time
 - ✓ Need to be sure they are paying providers that are licensed
 - ✓ Need a source for up-to-date non-Medicaid service provider licensing and certification data
 - ✓ Reimbursement for community providers
 - ✓ There is more functionality in the new MMIS, and B-HIP will take advantage of that additional functionality
- Tickler system for future follow-up after initial contact
- Robust feedback (reporting capability) to agencies that send data to B-HIP
 - ✓ Actively engage providers in B-HIP so they will use the data, rather than dumping data into a "black hole" at the State
- Legal status – include data about court and jail mandates
- Longitudinal tracking

- ✓ Capture data about the lives of individuals once they've left the behavioral health systems of care, e.g. whether they are being successful or not successful
- ✓ Capture data about why an individual re-enters the system; make re-entry data available as quickly as possible (falls into outcome tracking function of B-HIP)
- ✓ Track individuals who are no longer receiving services as often as an "active" individual with an "open" case record, but needs check-ins every 3-6 months. There is an outstanding parking lot issue that is still under discussion about if and when a provider "closes" a client in B-HIP
- ✓ Need to know how vendor systems maintain information about individuals whose episode of treatment is over, but still want to maintain information about the individual; be sure this is included in the list of sub-processes
- Individual's benefits – captured with eligibility information
 - ✓ Need to capture an individual's benefits as they change, which they do continually
 - ✓ Need information about what is included in each benefit
 - ✓ What happens when people go to work, e.g. what does it do to their benefits
- Fiscal impact of treatment services
 - ✓ How long an individual is in each service
 - ✓ Calculate the fiscal impact of those services
- Need ability to redact/block out data so certain groups cannot see certain data
 - ✓ Field level security may be needed; however, COTS systems are likely to restrict security to modules rather than field levels
- Robust incoming and outgoing referral tracking
 - ✓ Track referrals both from hospital to community, to and from acute and residential care facilities
 - ✓ Need to be able to use the referral system for lawsuit prevention, e.g. Ohmstead lawsuit
 - ✓ Track everyone leaving OSH and share that information with acute care facilities
 - ✓ It's a liability issue, e.g. we've already tried this, so lets try something different this time
Need data about the referring organization, e.g. contact name, address, date of referral
 - ✓ Track OSH discharged patient referrals, e.g. where referred, are certain programs not accepting individuals people, are certain individuals not getting accepted and why they are being denied
 - ✓ Needs to be robust functionality with good reporting capability
 - ✓ AMH should design some set of questions to ask vendors participating in the Vendor Fair how well they handle incoming and outgoing referral data
- Incident management tracking and reporting at State hospitals
 - ✓ Access to that information is an issue of confidentiality in B-HIP, e.g. may need field level security
- Need to track activity scheduling for treatment
- Case management tracking
 - ✓ Monitoring time spent in particular activities for both individuals and treatment personnel
 - ✓ Ability to provide and track centralized treatment, e.g. staff move between units at OSH
 - ✓ Need to know where patients are at any given time
 - ✓ Need to know where personnel are at all times
 - ✓ Need to be able to schedule treatment rooms/areas
 - ✓ Need same functionality on out-patient side
- Track patient authorizations and consents in State hospitals
 - ✓ There is an issue with expiring authorizations and consents, so need ticklers to notify when expires

- Track duration of service and point of service in community programs
 - ✓ Current MMIS doesn't track this data
- Supportive employment tracking
 - ✓ This service provides support to individuals with mental illness so they can be successful
 - ✓ Track as an individual service rather than specific individuals
 - ✓ Currently has a CPT code for this service
 - ✓ Need to track how many individuals entered supportive employment, were they competitively employed, duration of employment, etc.
- Incident reporting component facilities will have to support

Additional ideas/thoughts about the B-HIP project generated by the groups included:

- Consumer group input in the B-HIP process would be very valuable and helpful to meet HIPAA confidentiality rules, e.g. consumer council at OSH
- During the Vendor Fair, ask vendors to demonstrate what their system captures/supports around an individual's homeless status
- One group suggested using the term "continuum of care" rather than "after-care" in process descriptions
- Community programs need to complete criminal history checks on potential new employees that are time consuming and costly. May want to maintain criminal screening profiles in B-HIP to save community programs time and cost in obtaining
- Abuse reports
 - ✓ Office of Mental Health does abuse investigations.
 - ✓ When abuse is substantiated or unsubstantiated, programs need to know
 - ✓ That information is needed across DD, Children's Services and Behavioral Health services
 - ✓ This is a policy issue for AMH, as there is an issue of confidentiality
- There are all sizes and sophistication of community providers
 - ✓ There is a need for community providers who currently use robust e-systems to directly interface with B-HIP (or upload data into B-HIP) and avoid duplicate data entry into B-HIP
 - ✓ There may be a need for smaller community provider programs to actually utilize B-HIP for their own individual tracking
- Example was mentioned about the State of Utah's unique tracking system, e.g. they completed a successful study on suicide with their juvenile justice system to see if individuals received appropriate prevention and treatment services

Ben Kahn is receptive to all ideas for additional requirements. Stakeholders should send additional thoughts and ideas to Ben via e-mail to Ben.Kahn@state.or.us .

Matt Bailey reminded meeting participants that commercial off-the-shelf software products are usually initially produced according to industry standards at the time they are developed, they will often evolve as the industry evolves, so they might not "fit like a glove" and exactly meet the B-HIP requirements.

B-HIP VISION

Madeline Olson spoke about the importance of B-HIP and her vision for a new system (Attachment 8). She thanked everyone for taking time today to help DHS with this Project. She believes it is fitting she is doing this for state government now, as one of her first responsibilities when she came to work for the State was editing the CPMS User Manual. Madeline believes

DHS needs a data system that reflects where the State is headed with treatment systems, e.g. across all sites of care and all levels of treatment, so the State has information about individuals being served wherever they are in the system. It is critical to have the right kind of information to help individuals and to provide the best treatment.

Madeline continued to speak about her vision by pointing out DHS also needs electronic systems at the state hospitals to manage the various kinds of work that happens there. There is considerable support from the Governor and the Legislature to build a new facility to provide care to people who need that level of care. Patient records, pharmacy and medication management, dietary services and facility maintenance services all need to be integrated into a new system so DHS can make data-driven policy decisions and know the costs of those decisions. It is critical to integrate all information to provide the best possible level of care to Oregonians that need services from the State. It is critical to have modern kinds of tools to manage the state hospitals and the services provided at those hospitals. We need system that are flexible with robust data that gives us outcome information and can be adjusted quickly if we find some forms of treatment aren't working well. We need accurate to assure the taxpayers they are investing in programs where people are kept safe and are restored to a level of functioning that allows them to function in the community. Addictions and mental health disorders are highly treatable diseases. We have to have evidence we can provide that treatment well. Participants today are here to help us determine what kind of information we need to collect. There must be systems available that will meet most, if not all, of our needs. Today, you are helping us determine what we need. Madeline is currently preparing a presentation for the Ways and Means Legislative Committee that will be given early next week.

PROJECT CHARTER

Ben Kahn explained the purpose of the Project Charter and walked participants through the highlights of the B-HIP Charter so all would be aware of the Project structure. He reported on the current scope of the Project. B-HIP includes the two (2) OHS campuses and Blue Mountain Recovery Center (BMRC), plus 13 regional acute care hospitals and hundreds of community behavioral health alcohol, drug and mental health programs. The goal is to find a commercial off-the-shelf (COTS) system that comes closest to meeting the documented requirements for a new system. Ben spoke about the role and membership of the B-HIP Steering Committee, and then asked participants if they had any questions. One participant commented this was a demonstration of how projects that are well run work.

Ben clarified that the scope of the Project that was discussed 24 months ago has changed and expanded. Meeting participants agreed they felt comfortable about the change in the scope of the Project.

POLICY OPTION PACKAGE 104

Maynard Hammer, Deputy Superintendent of OSH, gave a short presentation about State funding processes and Policy Option Packages (POP). POP is used to address hospital replacements. Most systems are manual today at OSH and they cannot open a new hospital with the current systems. B-HIP is progressing at the same pace as the hospital replacement project. The request for B-HIP funding was merged into the hospital replacement request so the hospital components of B-HIP will be funded along with the beginnings of the hospital replacement project.

Maynard reported the “siting” activities for the new hospitals are underway. There is a large amount of support and momentum at the moment. If approved, the hospital replacement POP will provide funding, among other things, to buy land for sight locations and consultant time to help flesh out and document the business requirements, additional staffing for the hospital, etc. Preliminary planning and design for the North Campus is underway. Once funded, they will be able to contract for a design team. They are planning a nationwide search through the State procurement process for architects, engineers and planners to produce preliminary schematics and plans during the next biennium. Not a great deal of construction is expected in this biennium. The project is on schedule now and is moving along as per the Master Plan, Phase 2 report.

The Siting Plan will be delivered at the end of this month to the Legislature. If all goes well, the procurement will start soon. Financing is through Certificates of Participation, which look and act like a bond. Oregon does not have a constitutional provision that allows general obligation bonds, e.g. can't issue debt, so the fallback is long term financing that relies on the Governor and Legislature to fund the debt service that is not backed up by pledged revenues or taxes.

DHS has merged the facilities hospital management components to the hospital replacement funding package. The hospital facility project is the vehicle to fund and procure the new system to use in the hospitals and in the community programs. It is anticipated that the community programs will utilize a subset of the functionality implemented for the hospitals.

EDUCATIONAL AWARENESS EFFORTS

Ben Kahn spoke about the importance of educating appropriate parties about B-HIP.

Ben presented five (5) groups for which education about B-HIP should be provided, including:

- Hospital staff at the two (2) OSH campuses and at BMRC
- Community Service Providers of Mental Health and Addictions Services
- Stakeholder Organizations/Agencies, such as the Association of Community Mental Health Providers
- DHS/AMH personnel, including management and staff
- Oregon Legislature

Ben asked participants for additional ideas to add to this list. Participants made the following suggestions, listed in alphabetical order:

- Stakeholder Organizations/Agencies
 - ✓ Governor's Violent Crime and Drug Advisory Board
 - ✓ Local Mental Health Advisory Councils
 - ✓ Oregon Criminal Justice Commission
 - ✓ Managed Health Care Organizations (MHOs)
 - ✓ Law enforcement agencies
 - ✓ Local Alcohol and Drug Planning Committees (LADPCs)
 - ✓ Media on Electronic Records
 - ✓ National Alliance on Mental Illness (NAMI)
 - ✓ Oregon Advocacy Center (OAC)
 - ✓ Oregon Community Health Information Network (OCHIN)
 - ✓ Oregon Department of Corrections
 - ✓ Oregon Department of Justice

- ✓ Oregon Family Support Network
 - ✓ Oregon Hospital Association
 - ✓ Oregon Office of the Attorney General
 - ✓ Recovery Association Project (RAP)
 - ✓ Union stewards from Oregon Occupational Safety and Health (OSH) Service
 - ✓ University researchers
- DHS/AMH personnel
 - ✓ DHS Communications staff, e.g. to help get information to editorial boards

Ben asked “how much education do these stakeholders need?” Participants agreed an overview (one-page, two-sided yellow sheet handout) would be good information for many of the organizations. It will help bring them to the table if B-HIP is connected with how it will interface with their environment. AMH should develop a Speakers Bureau and packet of materials for each group. One participant expressed a desire to reference research data about how an electronic data collection and reporting system will save time for staff providing direct care.

One participant noted that the Consumer Advocacy Groups may have an objection to B-HIP related to confidentiality of information. It will be important to ensure they are aware of access and security of B-HIP data. Ben concluded this segment of the meeting by noting it was important AMH develop and follow a robust communication plan.

VENDOR FAIR

Debra Herrli spoke about Vendor Fairs. She was involved in a Vendor Fair for the Medicaid Management Information System (MMIS) and another one for replacement of the Child Welfare System.

What is a Vendor Fair?

Debra described a Vendor Fair as an invitation to vendors who think they have a product that might meet the State’s requirements to come to Oregon and demonstrate their product. It is not a formal bid and not held to select a solution. The way it has been done in the past in Oregon is the State issues a Request for Information (RFI) specifically to let vendors know Oregon wants them to come to a Vendor Fair to demonstrate their product.

Why hold a Vendor Fair?

A Vendor Fair helps solidify system requirements. It enables project management to see what’s out there in order to assure nothing has been missed. It also helps stakeholders see new ideas, better understand what is in the current marketplace and recognize new ways of doing work.

How is a Vendor Fair conducted?

Debra explained a Vendor Fair must conform to Oregon procurement standards. She described vendor fairs she had been involved with in the past. One vendor per day was scheduled. A standard agenda was developed and used for all vendors that described what the State wanted to see about their software products, allowing specific amounts of time for each vendor to demonstrate specific functionality the State wanted to see. She explained stakeholders didn’t have to attend the fair for an entire day if they were not interested in seeing all parts of a system being demonstrated.

Both pre-and post-briefing sessions were held for stakeholder participants. The Pre-Vendor Fair briefing covered what stakeholders can and can't do. For example, they can't compare one product to another because it suggests the State may select one from this process. They can say vendor A has a robust pharmacy component, but not that it's better than another vendor's pharmacy component. The Post-Vendor Fair briefing captured what participants thought about what they saw demonstrated after each session.

Debra's experience indicates it takes about 60 days to plan and complete the appropriate processes prior to the first day of the Vendor Fair. She thought Vendor Fairs were very interesting and fun. Participants are usually surprised to see what 'cool things' are available.

STAKEHOLDER VOLUNTEERS

Ben passed around clipboards with sign-up sheets to assist the State in various activities if any stakeholders want to participate. Participation requires a time commitment. The following individuals agreed to assist with upcoming activities:

Educational Awareness. Provide assistance designing and planning an educational awareness program, e.g. determining locations, topics to be discussed, lists of invitees, etc.

Educational Awareness Volunteers			
Name	Organizational Affiliation	Phone	E-Mail Address
Jeanine Basset	CODA, Inc.		jeaninebasset@codainc.org
Marion David	AMH		marion.david@state.or.us
Ted Ficken	OSH	503-945-0916	ted.ficken@state.or.us
Terry Mastin	AMH	503-945-6722	terry.n.mastin@state.or.us
Maria Walchli	BMRC	541-276-0810 ext. 302	maria.walchli@state.or.us

Documentation Review. Provide assistance reviewing materials developed to assure they are focused, easy to understand and interesting, e.g. educational awareness handouts, B-HIP updates, Request for Proposals.

Documentation Awareness Volunteers			
Name	Organizational Affiliation	Phone	E-Mail Address
Sharon Anderson	OSH	503-947-2332	Sharon.l.anderson@state.or.us
John Bischof	OSH - Administration	503-945-2937	
Nancy Frantz-Geddes	OSH - Administration	503-945-2858	
Robert Furlow	OSH	503-945-2968	rfurlow@state.or.us
Terry Mastin	AMH	503-945-6722	terry.n.mastin@state.or.us
Krishnan Seshadri	DHS, OIS	503-378-3317	
Leilani Tucker	DHS, OIS	503-945-9759	

Vendor Fair. Provide assistance with communication and planning, e.g. determining location(s), business processes / system functionality to be demonstrated, list of attendees, etc.

Vendor Fair Volunteers			
Name	Organizational Affiliation	Phone	E-Mail Address
Joni Detrant	OSH	503-945-2981	joni.r.detrant@state.or.us
Robert Furlow	OSH	503-945-2968	rfurlow@state.or.us
Kelly Knight	AMH	503-945-9726	Kelly.C.Knight@state.or.us
Terry Mastin	AMH	503-945-6722	terry.n.mastin@state.or.us
Nena Strickland	OSH	503-945-7128	nena.s.strickland@state.or.us
Maria Walchli	BMRC	541-276-0810 ext. 302	maria.walchli@state.or.us

CLOSING COMMENTS AND FINAL QUESTIONS

Ben asked if anyone had any other questions and told stakeholders they could reach him through e-mail or phone if questions arose or they had new ideas to share. Ben thanked everyone for attending and requested they complete the short meeting evaluation form. The meeting adjourned shortly after 12 noon (PST).

MEETING EVALUATION

Of the 45 B-HIP Stakeholders attending the meeting, 28 participants completed a one-page Meeting Evaluation Form developed by FOX, with the following results:

Number of Respondents	Participants Work Area
10	AMH
8	State Hospital
	Acute Care Center
	Research
1	Community Mental Health Program
1	Community Addictions and Drug Program
7	Information Technology (State and Community)
1	Advocate

	Number of Respondents				
	<i>Strongly Agree</i>				<i>Strongly Disagree</i>
	Rating	1	2	3	4
Presentations about B-HIP were valuable.	14	11	1		2
Discussions about B-HIP Charter and Policy Option Package were valuable.	13	11	2		2
Discussions and activities about new B-HIP requirements were valuable.	17	6	3	1	1
Presentations and discussions demonstrate B-HIP is "on track."	17	8	1		2
I support B-HIP and will actively participate in ongoing Project activities.	21	4	1		2

Comments included:

- ✓ "It's valuable to have information on this project to advocate for it in the community."
- ✓ "The handouts were very helpful."
- ✓ "We need warm donuts."
- ✓ "Great update. Good to see additional AMH and hospital participation."
- ✓ "Well organized with great deal of information in short period of time. Good energy. Presentations allowed stakeholders know that B-HIP is active and moving forward as fast as possible - not just an idea that stalemated."
- ✓ "If possible, less reading directly off slides."
- ✓ "Business case info good - too much per screen - too small font. Speaker spoke too softly. Ben communicates in a very organized fashion - great PowerPoint."
- ✓ "Facility: broken chair and absence of window curtain (a distraction from presentation.)"
- ✓ (Policy Option topic was not valuable.)
- ✓ "Nice job."
- ✓ "Had some difficulty tracking what is/isn't included. However, don't really see a solution. Great job by all."
- ✓ "Thanks! Please keep Multnomah County in the loop."

B-HIP STAKEHOLDER'S MEETING PARTICIPANTS

Name	Organization	Phone	E-mail Address
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Name	Organization	Phone	E-mail Address
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Terry Mastin	AMH – Housing	503-945-6722	terry.n.mastin@state.or.us
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PRESENTATION ON B-HIP FROM B-HIP BUSINESS PLAN

(To obtain a copy of the Microsoft PowerPoint slides, contact Ben Kahn at Ben.Kahn@state.or.us)

Behavioral Health Integration Project B-HIP

PREPARED FOR THE
OREGON DEPARTMENT OF HUMAN SERVICES (DHS)
ADDICTIONS AND MENTAL HEALTH (AMH)

PRESENTED TO THE
B-HIP STAKEHOLDER MEETING
February 8, 2007
8:30 – 12:00 noon
Best Western Black Bear Inn
Salem, Oregon

Behavioral Health Integration Project B-HIP

Background and Current Environment

Over 200,000 individuals are currently provided mental health and addiction services annually in the State of Oregon through the State hospitals and community programs supported by the Department of Human Services' Addictions and Mental Health Division. OSH and BMRC, located on 3 campuses, have a total of 43 doctors and 221 nurses. There are 24 total wards (units) in the 3 State hospitals, with 3 shifts of workers at each hospital.

Two (2) legacy systems are used to capture information about individuals and the services they receive in the State hospitals, acute care hospitals and community-based programs. Both systems were built in-house, are mainframe systems written in COBOL on an IBM OS/390 platform. CPMS and OP/RCS were built in the early 1980s. Since that time, each system has been modified over 1,000 times, with ongoing continual modifications made daily. It is extremely difficult and very time consuming to make these modifications, and some needed modifications cannot be made at all because of the antiquated technology.

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Current Internal Problems and Challenges

Following are some of the problems and challenges faced by OSH, BMRC, AMH and the community service providers and acute care hospitals as a result of the antiquated applications used to collect and report individual and service information:

Poor tracking of individuals receiving services. There is an inability to identify who receives services, where and when an individual receives services, which services were received and the individual outcomes resulting from those services.

Absence of important clinical functionality at the State hospitals. For example, paper clinical documentation, paper medical records and paper pharmacy inventory leads to less than optimal care and treatment.

Limited access to clinical information. Only one person at a time can view or enter data into a paper medical record. Access to the record can be problematic when many members of an interdisciplinary treatment team need access.

Operational inefficiencies distract from individual care. Costly redundant data entry, manual data collection and report preparation, clinicians mired in paperwork and inaccurate data that requires correcting all take time from treatment and care. 2

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Current Internal Problems and Challenges (Continued):

Costly system modifications to meet new mandates. Antiquated technology makes it difficult and often impossible to make system modifications to address new State and Federal requirements, e.g. national outcome measures and national provider identifier, or new clinical needs, such as new lab tests and reference categories.

Insufficient data leads to inaccurate forecasting. Current systems do not have the capability to capture all information necessary for accurate forecasting of the need for services and the federal matching funds anticipated in future budgets, leading to budget shortfalls. Additionally, CPMS requires users to open and close a client record for each episode of care. There is no incentive to close client records, however, leading to overstated caseloads, estimated to be currently between 10% - 25%. DHS has been consistently challenged with accurate and timely forecasting, but has a critical need to do so.

Inefficient use of limited resources. Daily business processes involving CPMS and OP/RCS are labor intensive. For example, to provide the data required in CPMS, personnel at the community-based provider agencies complete client registration forms. Roughly 60% of the agencies complete the forms on paper, and send the forms to AMH to be entered into the computer. AMH has data entry clerks devoted solely to entering CPMS data, which is entered on an ongoing basis as forms are received. Roughly 40% of the agencies enter their data into an Access application or their own in-house system, and then submit the data files to AMH on disk or via email. 3

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Current Internal Problems and Challenges (Continued)

Inaccurate, incomplete, or questionably valid data. Inaccurate or incomplete CPMS data include use of incorrect birth dates, limited identifying information (e.g., no social security number), intentional obfuscation by clients, high turnover of data entry clerks, an antiquated computer system, and lack of incentives for community and acute care providers to submit timely, accurate and complete data.

Poor stewardship of capital assets. The State must exercise good stewardship when maintaining and managing its physical assets, but that is difficult without robust electronic tracking systems. The State hospitals currently have no easy method of managing the tracking facilities maintenance activities, warranties on equipment, etc.

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Current External Problems and Challenges

In the quarter century OP/RCS and CPMS have been in place, the external environment in which Oregon State facilities and community-based programs operate has become more challenging. For example:

Pressures on public funding sources have intensified. At the same time, mental health services are increasingly paid for out of public monies, with public funding paying for 63% of mental health services in 2001, up from 57% in 1991; the share of mental health spending to inpatient services declined 12 percentage points to 28% during the same period.

Payer requirements for reimbursement have become more complex. For example, inpatient psychiatric Prospective Payment System (PPS) took effect July 2005.

Accreditation requirements have burgeoned. For example, JCAHO quality improvement reporting has increased.

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Current External Problems and Challenges (Continued)

Legislative and regulatory requirements and compliance have increased in such areas as:

Health Insurance Portability and Accountability Act (HIPAA) and accompanying DHHS rules around privacy of information, standardized transactions and code sets when billing for health care services, security of electronic health records, and the National Provider Identifier.

Evidence-Based Practices are challenging to substantiate without an electronic system to document compliance.

Medicare Modernization Act requires the electronic submission of pharmacy claims for Medicare (Part D) enrolled patients.

Reporting requirements have increased. For example, SAMHSA national outcome measures.

Increased scrutiny. The mental health industry has received greater public, regulatory, and legislative scrutiny, and community awareness has heightened. The State is increasingly held responsible for meeting Federal and State legal regulations, both by advocacy groups and the courts.

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Current External Problems and Challenges (Continued)

Increased need to coordinate. The need to communicate and coordinate with other mental health system providers and stakeholders has become an imperative, e.g. acute care hospitals' ERs and evaluation units, other acute psychiatric facilities, long-term care facilities, Department of Corrections Special Management Units, Psychiatric Security Review Board, community-based treatment facilities and outpatient services, private providers, and other county and State agencies, such as law enforcement data systems.

Increased pressure to communicate electronically. The Federal government is clearly on record for promoting increased use of information technology in health care, particularly electronic transactions when billing for health care services (HIPAA and MMA) and electronic medical records.

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Current Status vs. Desired Improvements

Current Status	Desired Improvements
Inability to readily share individual/patient information	Electronically and seamlessly share individual information among those with a need to know
Inability to track individuals/patients across the continuum of behavioral health care through recovery	Ability to readily track individuals through the transition from one treatment environment to another, e.g. acute care hospitals to State hospitals to community provider services through monitoring of recovery
Clinical personnel are mired in paperwork	Clinical personnel are freed to provide additional direct individual care and support
Duplicative processes for individuals/patients served and public and private service personnel	Elimination of duplicate processes and data entry for individuals receiving and personnel providing services
Real-time data are not available to providers who "own" the information	All data are readily available real-time to those with approved access
Reports and outcome data are difficult, if not impossible, to produce	Ad hoc reporting capability and outcome data are intuitive and readily available for all system users

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Current Status vs. Desired Improvements

Current Status	Desired Improvements
All information needed for reporting purposes is not collected	All information needed for reporting purposes is collected and easily reported
Billing to Medicare and other third party insurers is cumbersome and limited	Billing is seamless and meets Federal standards and rules, e.g. HIPAA transaction and code set requirements, MMA requirements, electronic data interchange (EDI); allows the full range of billing, tracking and reconciliation
Inflexible, antiquated technology	State-of-the-art technology that is easily modified, as required
Internally built applications requiring excessive IT support and maintenance	COTS solutions, including vendor support and maintenance
Limited software application support	Robust IT support that keeps the users current and is responsive to the business needs
Data overload, but no information	Information rich environment that supports clinical services

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Behavioral Health Integration Project B-HIP

Cost Estimate & Schedule

B-HIP Estimated Cost

The total cost of a new mental health and addiction services hospital management system is estimated to be \$73.3 million over eight years, with \$33.7 million in non-recurring costs and \$39.6 million in recurring costs over the eight-year period. The costs include business process improvements and business process reengineering, requirements gathering, system selection, contracting, installation, data conversion, customization, deployment, and training. In addition, hardware, software licenses, software maintenance, network, telecommunications, and facility infrastructure costs are included.

B-HIP Estimated Schedule

B-HIP will span several years and could require up to 44 months of elapsed time from project approval to full deployment and project close-out.

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Behavioral Health Integration Project B-HIP

B-HIP Bottom Line

Under the current environment, using 1980s vintage information technology to meet 21st century business needs will be inadequate at best, dangerous at worst, and will:

- Jeopardize individual care.
- Place OSH at risk of losing JCAHO accreditation.
- Make it highly unlikely that BMRC can attain JCAHO accreditation.
- Place OSH at risk of losing Medicare certification, Medicare revenue and the associated matching State funds.
- Result in unbilled charges, reimbursement denials and lost revenue at both OSH and BMRC.
- Prevents achieving the goal of integration of hospital and community services that reflect more of a continuum that is specific to an individual's needs.

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Improves Individual Care
through:

- Improved efficiency and effectiveness of treatment resources
- Seamless integration of services
- Increased emphasis on individual-centered planning and recovery
- Easier transition to community-based programs

Improves Community Program Services through:

- Provision of real-time client information from hospital through community transition
- Added time for treatment services
- Improved capacity to share comprehensive information
- Elimination of redundant data entry

Improves State Hospital Services through:

- Increased time to provide direct patient care
- Electronic health record and timely/accurate patient information
- Support of continued accreditation and hospital funding
- State-of-the-art medication management
- Improved operational management decisions



Improves reporting and increases revenues through:

- Support for Evidence-Based Practice data
- Improved billing and revenue cycle management
- Ease of information to Oregon legislature and other funding sources
- Improved content and accuracy of information

Reduces Risk through:

- Reduced risk of JACHO Accreditation Failure
- Reduced risk of revenue loss from SAMSHA Block-grant
- Reduced risk of patient death/injury from clinical care errors
- Reduced risk of patient relapse/re-institutionalization from "gaps" in care.

B-HIP, the First 2 Years

Macro-Level B-HIP Functional Requirements

Developed during Joint Application Requirements (JAR) Sessions held July 20-22, 2005

Approved by B-HIP Steering Committee on October 17, 2005

<p>1.0 Screening and Intake/Enrollment. The process of completing a group of initial administrative functions necessary to provide behavioral health services to an individual.</p>
<p>2.0 Clinical Evaluation and Assessment. The process of completing and capturing information about initial and ongoing clinical evaluations and assessments to determine an individual's service and support needs.</p>
<p>3.0 Counseling and Care Management. The process of developing, implementing and tracking plan(s) for service(s) and support(s) for each individual.</p>
<p>4.0 Treatment and Recovery/Aftercare Support Services. The process of tracking an individual's behavioral health (mental health and addiction) treatment services, and recovery/aftercare support and maintenance services once active treatment has been completed.</p>
<p>5.0 Medication Management. The process of tracking medications administered to individuals in the treatment of mental health and addiction disorders.</p>
<p>6.0 Education, Prevention and Outreach Services. The process of tracking population-based and consultation-type activities designed to prevent instances of addiction and improve mental health as part of a total system of behavioral health care.</p>
<p>7.0 Service Completion/Transition. The process of completing a group of functions necessary to discontinue an episode of care or transition an individual through the behavioral health continuum of care.</p>
<p>8.0 Service Utilization, Outcome Tracking and Reporting. The process of monitoring and reporting behavioral health services utilization and individual outcomes.</p>
<p>9.0 Legal Status. The process of tracking individuals involved in civil and criminal cases.</p>
<p>10.0 Licensing and Certification Management. The process of tracking OMHAS service provider's licensure, certification and accreditation.</p>

Oregon Department of Human Services

**Hospital Management System (HMS)
Macro-Level Functions / Processes**

Developed 4/20/2006

1.0 Admit/Discharge/Transfer

The process of completing a group of administrative and clinical functions necessary to admit/transfer patients to a behavioral health facility, and discharge them from the facility.

- Pre-Admission
- Admission
- Transfer
- Discharge Coordination / Follow-up / Transition

2.0 Patient Care and Services / Electronic Medical Record (EMR)

The dynamic process of storing, maintaining and providing access to an Electronic Medical Record (EMR) containing patient clinical data available to authorized caregivers for the express purpose of providing treatment and tracking individuals/patients and services.

- Master Patient Indexing (MPI)
- Automated Assessment Tools
- Treatment / Service Plans
- Computerized Patient Order Entry (CPOE)
- Patient Services
- Nursing Care Allocation
- Acuity Determination and Events
- Incident Reporting
- Infection Control
- Patient Progress Notes
- Activity Scheduling
- Charge Slips
- Service Plan, e.g. Individual's Goals, Interventions, Diagnoses, Persons Responsible, etc.
- "Alert" Messages and "Pop-Up" Reminders
- Progress Notes
- Nursing Daily Reporting, e.g. specific events unit to unit over 24-hours of care; aggregate progress of units

3.0 Medical Services

The process of electronically documenting pharmacy operations to include medication/treatment orders entered, medication/treatment administered, PRN reason, patient response, clinical result data, patient medication profile, drug information and patient education, and pharmaceutical inventory management.

- Medical Clinics
- Other Medical Services

4.0 Pharmacy / Medications Management

The process of electronically documenting pharmacy operations to include medication/treatment orders entered, medication/treatment administered, PRN reason, patient response, clinical result data, patient medication profile, drug information and patient education, and pharmaceutical inventory management.

- Formulary Management
- Medication Database
- Provider Profiles, e.g. prescribing practices and physician
- Automated Ordering
- Point-of-Care Application
- Point of Sale Processing
- Clinical Flow Sheet
- Electronic Medication Administration Record (MAR)
- Informed Consent and Involuntary Administration
- Drug Information and Patient Education tracking
- Rx Inventory Management
- Outpatient Labeling
- Costs
- MMAD (Medicare Modernization Administration Act, Part D)
- Scheduled Drug Tracking and Security

5.0 Laboratory Services

The process of electronically documenting laboratory operations, to include order entry and laboratory administration, laboratory examinations performed, clinical results data and quality control. The process supports at least the following disciplines: biochemistry, hematology/serology, hormone/tumor markers, drugs/toxicology, immunology, urine/stool/fluids, virology and microbiology.

- Order Requisition Entry
- Specimen Collection and Verification
- Results Entry
- Results Verification
- Results Inquiry
- Anatomical Pathology
- Point of Sale (POS)
- Lab Costs
- Lab Inventory
- Quality Control

6.0 Nutrition / Dietary Services

The process of electronically managing food and nutrition services to include clinically and culturally appropriate food service that meets current dietary guidelines and physician's specifications as a component of treatment for patients.

- Patient Dietary Assessments
- Patient Diet Records

- Special Diets
- Nutrition Referrals
- Menu Development
- Nutritional Analysis
- Patient Menu Selection
- Food/Supplies Ordering
- Food Service Inventory
- Hazard Alert Critical Control Points (HACCP)

7.0 Utilization Review / Quality Assurance / Quality Improvement

The process of monitoring and reporting on service utilization and patient outcomes.

- Pre-authorizations
- Actual Service vs. Authorized Service Tracking
- Continued Service Authorization
- Patient/Individual Outcomes
- Documentation
- Conditional Release Planning
- Monitoring Quality of Patient Care Provided

8.0 Administration and Finance

The process of collecting financial information to ensure optimal patient/resident care, operational support, resource management and financial and statistical analysis capability.

- Financial Accountability
- Budget Tracking and Management
- Licensing, Credentialing and Privileges
- Management Reporting
- Human Resources
- Fixed Asset Management

9.0 Facilities Management / Plant Maintenance

The process of planning, managing and operating the facilities, including the physical plant, assets, equipment and space. This includes preventative and routine maintenance, capital replacement, work order management and resource allocation, fixed assets, custodial, housekeeping and laundry, security, and JACHO environment of care (hazardous materials, utilities, medical equipment, life safety, emergency preparedness, safety and security – HUMLESS) reporting.

- Preventative Maintenance
- Routine Maintenance
- Capital Replacement
- Work Order Management and Resource Allocation
- Capital Asset Planning
- Management of Warranties
- Custodial
- Laundry

- Housekeeping
- Keys and Locks
- Security Interface with HR and Staff Certification
- Gate Control
- Identification of Employees
- Badges
- Support JACHO environment of care (HUMLESS - hazardous materials, utilities, medical equipment, life safety, emergency preparedness, safety and security)
- Fixed Asset Management, e.g. inspection & preventive maintenance of biomedical equipment, fixed asset inventory
- Warehouse – materials distribution; fixed asset system track physical plant assets, but not warranties, etc.

10.0 Reporting

The process of collecting, analyzing and generating reports about a variety of patient and facility data. This includes bed census, length of stay, patient survey data, incident reporting, etc.

- Patient Survey Data
- Standardized Reports, e.g. Bed Utilization
- JACHO and Other Accreditation Statistics
- Data Warehouse/Data Mart
- Dashboard Reporting/Business Intelligence
- Ad Hoc Reporting Capability
- Trust Accounts
- Restrictive Even Reports
- Incident Reports

Typical HMS Functions/Processes	Associated B-HIP Functions/Processes	Unique HMS Functions/Processes	Unique B-HIP Functions/Processes
1.0 Admit/Transfer/ Discharge	1.0 Screening and Intake/Enrollment 2.0 Clinical Evaluation and Assessment (some subfunctions/processes) 4.0 Treatment and Recovery/Aftercare Support Services (some subfunctions/processes) 7.0 Service Completion/Transition (some subfunctions/processes)		
2.0 Patient Care/Services	3.0 Counseling and Care Management 2.0 Clinical evaluation and Assessment (some subfunctions/processes) 4.0 Treatment and Recovery/Aftercare Support Services (some subfunctions/processes) 7.0 Service Completion/Transition (some subfunctions/processes)		
3.0 Electronic Medical Record		3.0 Electronic Medical Record	
4.0 Pharmacy/ Medications Management	5.0 Medication Management		
5.0 Utilization Review	8.0 Service Utilization, Outcome Tracking and Reporting (some subfunctions/processes)		
6.0 Administration/ Finance	10.0 Licensing and Certification Management (some subfunctions/processes)	6.0 Administration/ Finance	
7.0 Facilities Management/Plant Maintenance		7.0 Facilities Management/ Plant Maintenance	
8.0 Dietary Services		8.0 Dietary Services	
9.0 Reporting	8.0 Service Utilization, Outcome Tracking and Reporting (some subfunctions/processes)		
			6.0 Education, Prevention and Outreach Services

B-HIP Scope Diagram

