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

Draft for HITOC Review

Oregon Health Authority

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 healthcare 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 recommendations of the Behavioral Health Collaborative (BHC). Convened by OHA and composed of a diverse group of over 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 in order to provide access to relevant patient information across the spectrum of care. Accordingly, one of four overarching BHC recommendations include 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. In an effort to gain a better understanding of HIT and HIE adoption, use, needs, and challenges experienced by behavioral health agencies and to inform policies and strategies around these efforts, OHA conducted an environmental scan of HIT/HIE in Oregon's BH agencies (BH HIT/HIE Scan), which 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. About half of the agencies responded to the survey, representing 60% of all licensed programs in Oregon. 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 environmental scan

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.

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

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.

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 a necessity for improved patient care, reporting, and practice management.

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

Recommendations

Consistent with the BHC HIT recommendations, Oregon's HIT Oversight Council Priorities, and in response to the needs identified in the BH HIT/HIE Scan, the following recommendations are being put forth as OHA continues its efforts to improve the BH system.

1. Seek opportunities to provide **financial support** for adoption and effective use of robust EHRs and HIE participation that meet the needs of behavioral health agencies, clinicians, and patients.
2. Provide **technical assistance and learning opportunities** to support EHR adoption and effective use and HIE participation, as well as privacy and security needs, such as consent management.
3. Support agencies' opportunities for **collaboration and shared learning** with other behavioral health agencies around EHR adoption and effective use, HIE participation, and privacy and security issues.
4. Ensure behavioral health agencies can take advantage of statewide **robust HIT/HIE** efforts, and that these efforts address needs of behavioral health agencies, clinicians, patients, and other stakeholders
5. Seek opportunities to reduce reporting burden or otherwise provide **support for behavioral health agencies' reporting requirements.**

Additional Considerations

- Continue efforts to engage behavioral health agencies and conduct future environmental scan work.

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**, which provides financial incentives for EHR adoption and use to some behavioral health providers.
- The **HIE Onboarding Program**, which 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.
- The **Oregon Medicaid Meaningful Use Technical Assistance Program**, provides technical support for EHR adoption and use to some behavioral health providers.

- **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 HIT/HIE strategies currently underway, while also further considering the findings and recommendations identified in this report. OHA looks forward to continued behavioral health stakeholder and Tribal Government involvement in this work that is critical to the transformation of Oregon's behavioral health system.

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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, as they facilitate the sharing of information 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.

In 2017, the importance of HIT and HIE for behavioral health system transformation was underscored in recommendations of the Behavioral Health Collaborative (BHC). Convened by OHA and composed of a diverse group of over 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 in order to provide access to relevant patient information across the spectrum of care. Accordingly, one of four overarching BHC recommendations include 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, a number of strategies are currently underway to support the various technology-based aspects of the behavioral health care system, including 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 1 OHA-licensed program) inquiring about HIT and HIE needs, investments, uses, challenges, and priorities. In-depth follow-up interviews were conducted 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 broke new ground in our understanding of the overall picture 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.

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Online Survey

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

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. About half (49%) of the agencies responded to the survey, representing 60% of all licensed programs in Oregon.

Agency size	# of Agencies	Response Rate
Single Program	57	44%
Two Program	28	51%
Small (3-5 Programs)	25	56%
Medium (6-10 programs)	14	56%
Large (11+ Programs)	9	60%
Total Respondents	133	49%

Agencies who 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.

Population Density	# 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%

There was a high engagement by responding agencies as evidenced by thorough completion of the survey and more detail than required being provided via "other" responses; over three quarters of the respondents expressed interest in participating in a follow-up interview.

Program Type	# 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 Programs Represented in Responses	522	60%

Limitations of the Scan: Though almost half of Oregon's agencies with at least one licensed behavioral health program participated the survey, about half did not. Though it is not possible to know for sure, it is likely that agencies who participated in the survey are those who are more engaged in HIT/HIE, so the results described below reflect their experience and should not be extrapolated to the non-responding agencies who may in fact have different experiences, challenges and needs. Further, behavioral health providers not offering a licensed program, such as private practice providers, were not in scope for this survey.

In-depth Interviews

Based on information collected via survey, a sample of 20 agencies representing various agency characteristics was identified and invited 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 was able to complete in-depth follow-up interviews with 12 agencies. 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. Much was learned through these conversations which helped deepen OHA's 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 BH System.

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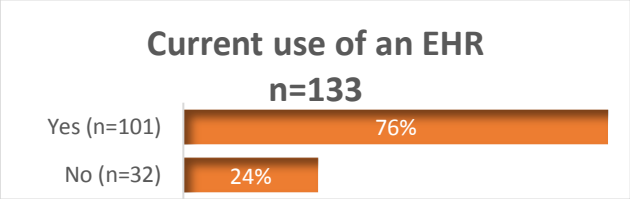
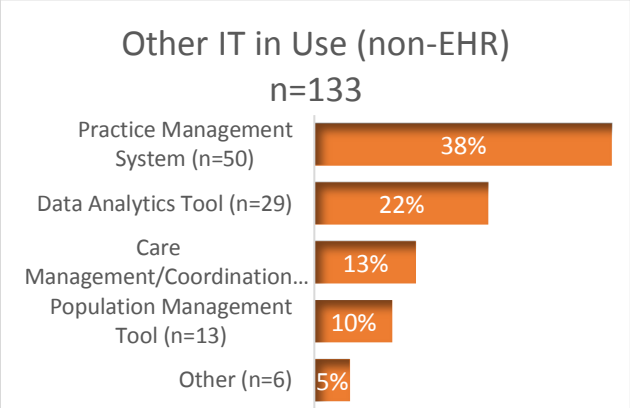
Behavioral Health HIT/HIE Environmental Scan Results

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.





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 with an EHR in the current sample. However, the responding agencies represent 60% of all licensed Oregon behavioral health programs, so it is clear that 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 Certified EHR Technology (CEHRT) that has been so instrumental in driving high rates of EHR adoption among Oregon's physical health providers.[1] Indeed, most of the agencies who have not yet adopted an EHR reported financial costs as a barrier and 70% of agencies who have adopted an EHR identified financial cost as a challenge.

EHR challenges for those who have an EHR			
	Challenge	**Count**	**Response Rate**
1	Financial costs	71	70%
2	Unable to exchange information with other systems	55	54%

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

In-depth interview highlights:

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

[1] 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, and 32 new behavioral health providers have attested in program year 2016. The program runs through 2021, but is now closed to new enrollees.

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 require regular EHR modifications as program requirements for data tracking change, increasing maintenance costs. A few agencies reported various informal efforts to manage EHR costs, like 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.

Top EHR systems	Number of Agencies
Credible	11
Care Logic- Qualifacts	10
Epic	8
NextGen	6
OWITS	4
OCHIN-Epic	4
Evolv	4
Clinicians Desktop-The Echo Group	3
Centricity - GE	3
All others	57
Total # of agencies (some reported more than 1 system)	110

IS YOUR EHR A SIGNIFICANT FINANCIAL BURDEN?

"It's a significant financial investment…I wouldn't call it a burden."

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

Given the diversity in programs and services offered across behavioral health agencies (e.g., mental health or substance use only versus both, requiring different EHR functionality for safeguarding protected information; or some agencies offer additional social service supports requiring the tracking and management of different data), it is challenging for them to use an EHR "off the shelf." 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.

"If you want a system to function correctly, it needs a lot of maintenance…
You need somebody with expertise…

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 whom (9 of 10 agencies) did not share information electronically across these systems.

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

Based on the survey responses, most agencies had invested in IT staff although about 30% had no staff but had other IT support, and 14% with no support. EHR adoption was particularly difficult for agencies that lack in-house IT support. One interviewee discussed the challenges

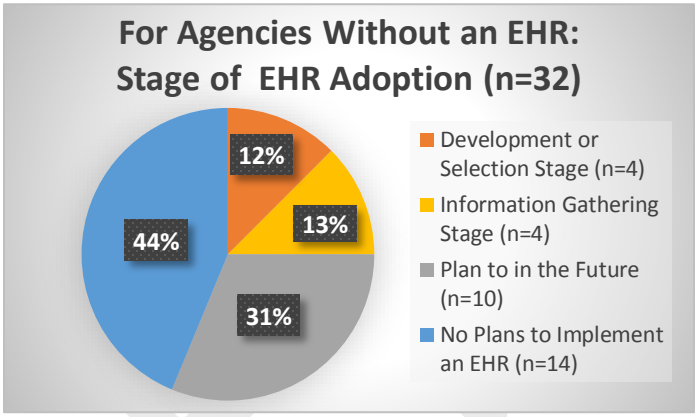
"Getting an EHR as comprehensive as we need is challenging…"

of being a clinician working with the vendor's EHR adoption staff, saying, "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 a 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 (1-5 program) agencies 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.

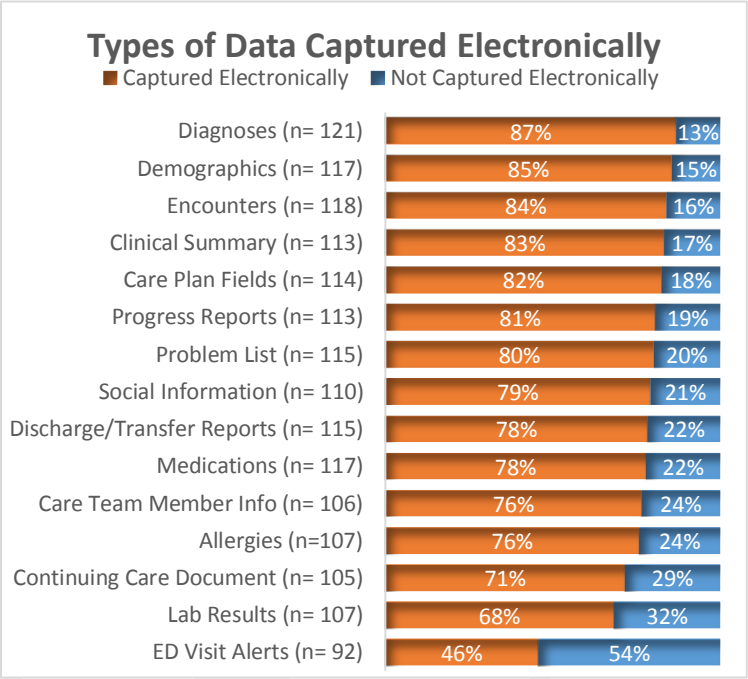
EHR Barriers for Agencies Who Do Not Have an EHR (n=32)

	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 infrastructure	15	48%

Over 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.

Result 1b. Behavioral health agencies are electronically capturing a broad array of information that is 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.



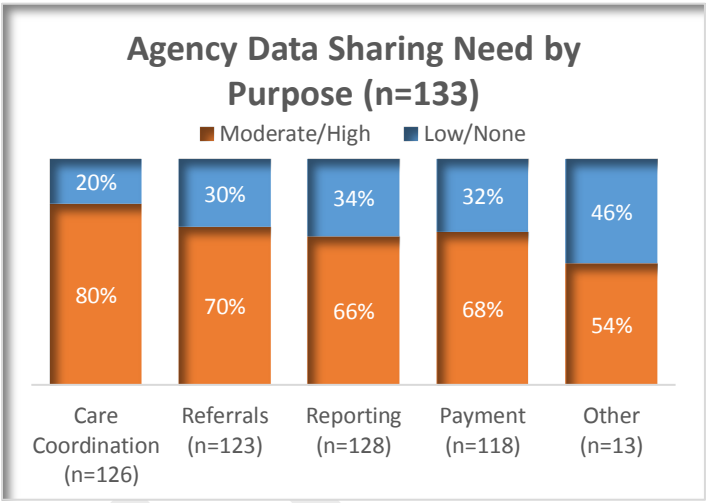
In-depth interview findings:

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

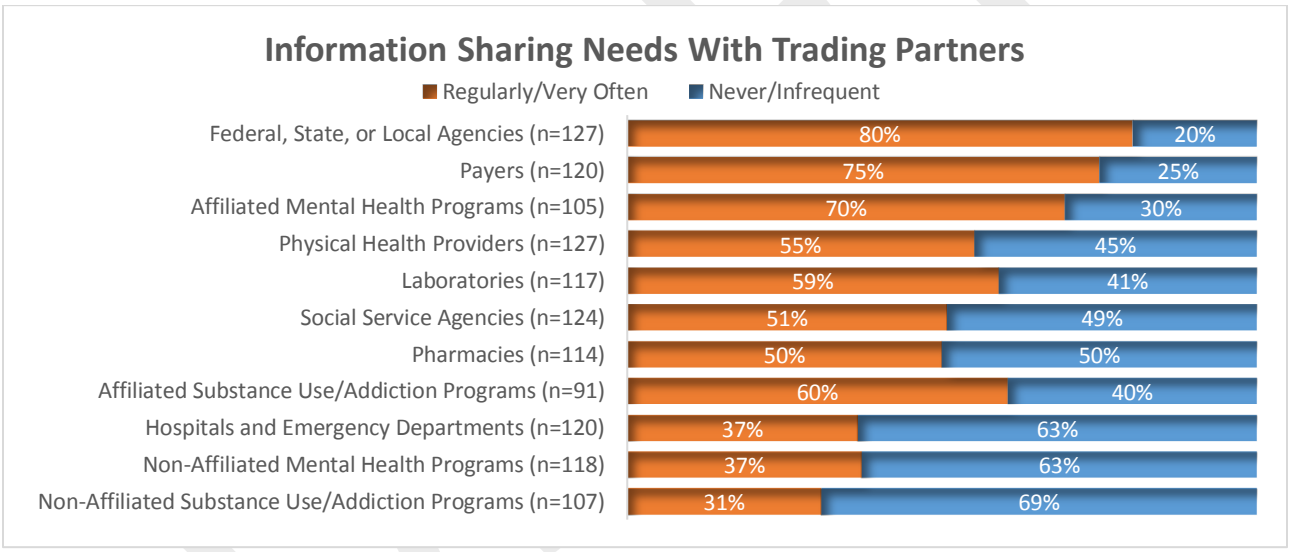
Conclusion 1: Most behavioral health agencies could benefit from additional HIT support.

- 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 have a need to exchange information with other entities however, few are doing so using modern electronic methods.

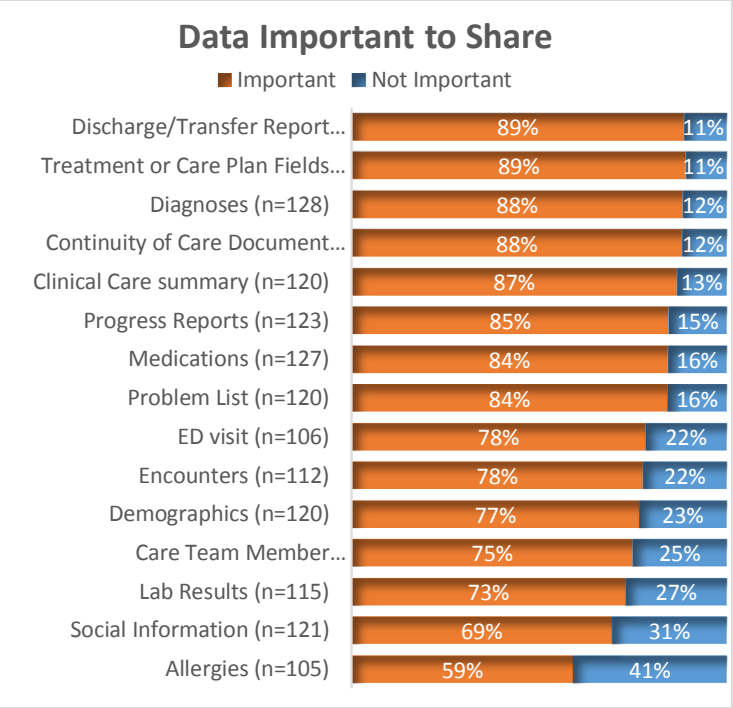


Respondents expressed a strong need to exchange data with other organizations for care coordination, referrals, reporting, and payment of services. In particular, care coordination was identified as a primary driver of information exchange, which may be associated with the frequently complex care needs experienced by individuals seeking behavioral health care. It is expected that behavioral health providers often need to both share and access information about their clients with other entity types.



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

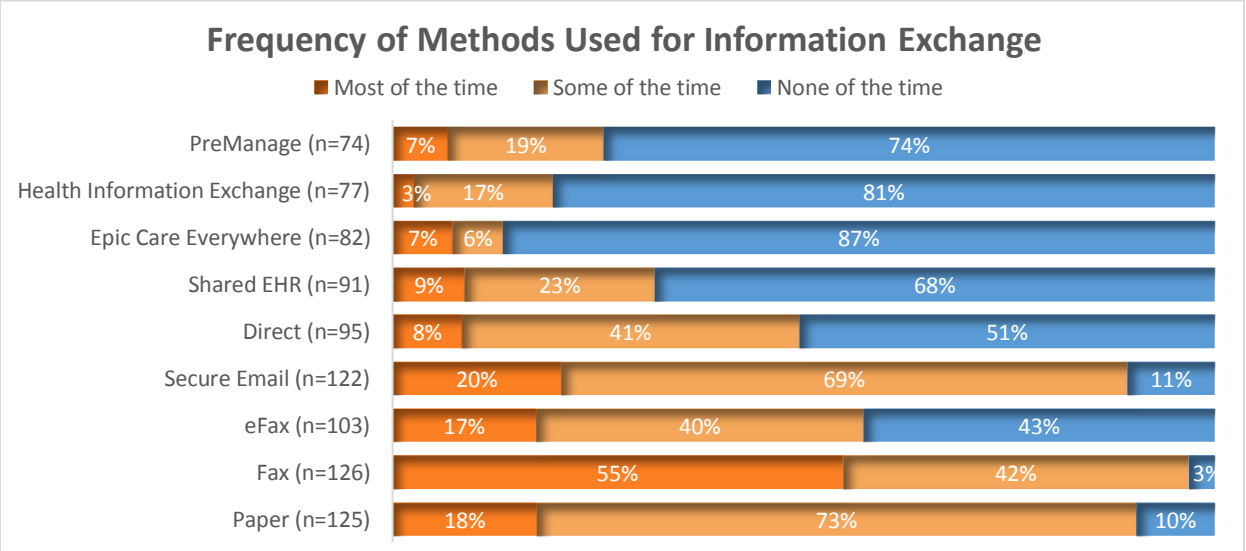
Agencies reported interest in a wide range of data – at least 60% of respondents reported that each core data element was important to share. Most of the commonly available information is relevant to behavioral health care and contributes to a more complete picture of the individual and their needs. Given that many behavioral health care recipients have complex needs and long histories of various treatments which 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.



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.

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 sharing of information 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.)



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'."

"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."

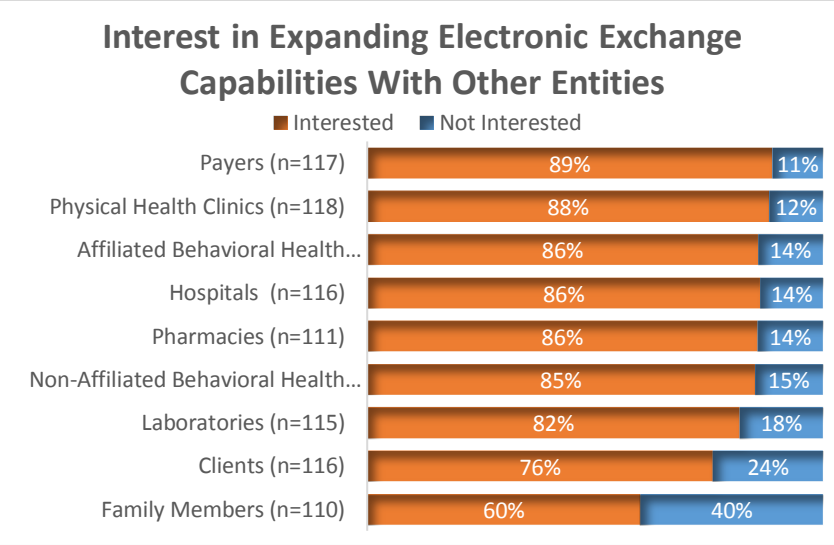
"Paper has more opportunities [than EHRs] for breaches of privacy. Faxing is just as bad – you never know who is standing at the other end."

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.

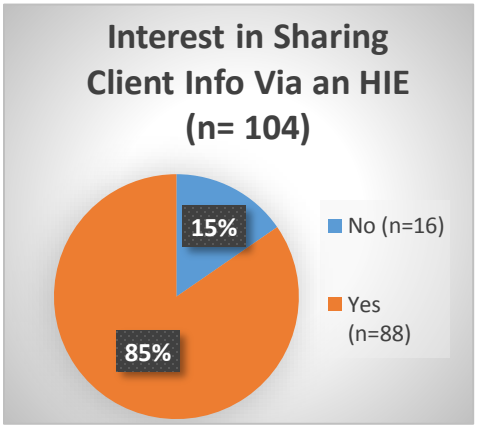
Multiple interviewees stated that the currently necessary reliance on faxing decreases speed and efficiency. Two interviewees also raised the issue of privacy concerns caused by faxing and paper document exchange.

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

Behavioral health agencies are eager to increase their capability to electronically exchange information with most entity types, including physical health entities, affiliated and non-affiliated behavioral health agencies, and clients/family members.



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



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

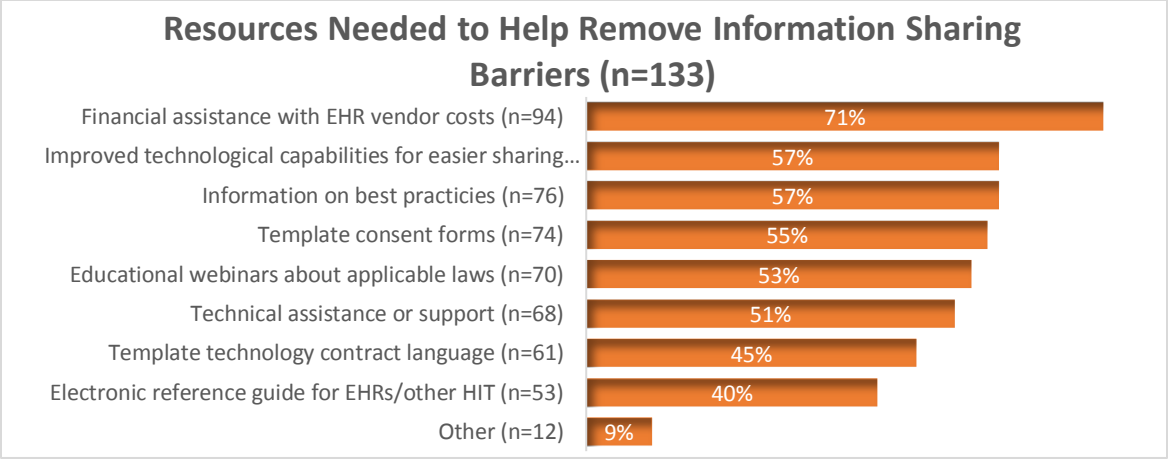
- Community Health Record
- Integrated eReferrals
- Hospital/Clinical Event Notifications
- Results/reports from Lab, Pathology, Discharge summaries, etc.

Connecting across sectors and data sources:

- 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

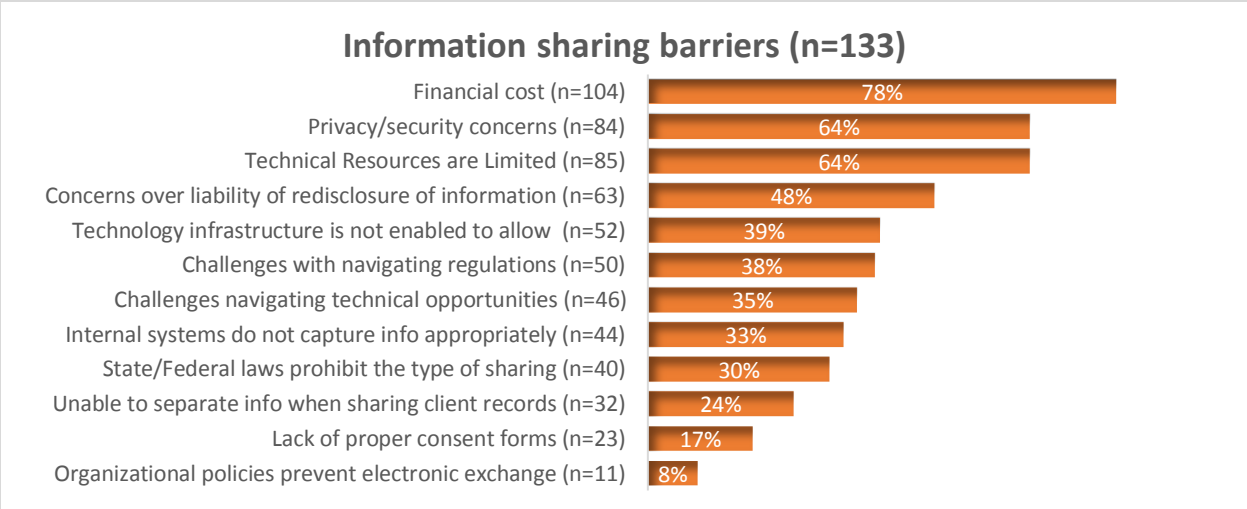
- Source of clinical data for payers,
- Some adding claims data for providers



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 barriers related to this were cited including, challenges with navigating regulations (38%), state/federal laws prohibit sharing (30%), unable 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 the requirements of the regulation, as well as challenges with the regulation itself, 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 many may be relevant to care that other members of the care team are providing. The regulation was updated in 2017, and some of the information sharing requirements were relaxed to improve care coordination. However, many providers are still struggling with lack of clarity about what the regulation allows and concerns about liability and privacy.

<u>In-depth interview findings</u>:

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, the majority of interviewees expressed the value 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.

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

Key Result 4: Data analytic tools and capabilities are a necessity 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 chart "Other IT in Use (Non-EHR)" on page 10). As in the physical health system of care, behavioral health providers are increasingly being required to report on various metrics and participate in value-based payment, and so are increasingly prioritizing their data needs. Though not a topic included in the survey, 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 experienced 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 their 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.

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Recommendations and Current OHA Strategies

The Behavioral Health HIT/HIE Scan results highlight the technology investments behavioral health agencies have made and the value they contribute to agency operations and client care. In addition, results shed new light on the HIT/HIE challenges and needs faced by behavioral health agencies. In response, OHA has put forth a series of recommendations, which include OHA's HIT/HIE strategies currently underway as well as new opportunities to explore. These recommendations align with those of the Behavioral Health Collaborative and with Oregon's HIT Oversight Council priorities. OHA looks forward to ongoing conversations with behavioral health stakeholders and tribal governments about how HIT/HIE can continue to support the transformation of Oregon's behavioral health system.

Recommendation 1: Seek opportunities to provide financial support for adoption and effective use of robust EHRs and HIE participation that meet the needs of behavioral health agencies, clinicians, and patients.

Behavioral health agencies who do not adopt an effective, robust EHR that meets behavioral health-specific needs will be significantly behind their counterparts and face increasing barriers to reporting, care coordination, and engaging in new payment models. As in the physical health sphere, many agencies who have adopted an EHR will face a decision about changing EHR systems to one that better meets their needs. Agencies will need to consider cost and value of making these types of business decisions – whether to customize, upgrade, add on a new tool, or change EHR systems completely. Financial costs and limited financial resources will be a key barrier for agencies ability to adjust as the marketplace and needs change.

Despite federal EHR incentive programs, most behavioral health providers do not meet eligibility criteria. Psychiatrists and psychiatric nurse practitioners with significant Medicaid patient volume would be eligible, but may be few enough staff within a behavioral health agency that costs associated with meeting incentive program requirements are not justified by the per-provider incentive payments available.

Medicaid EHR Incentive Program (MEHRIP)

MEHRIP offers eligible providers and hospitals financial incentives to adopt, implement or upgrade to certified Electronic Health Record (EHR) technology and become meaningful users of the EHR technology. Financial incentives are potentially available to a variety of physical health provider types (physicians, nurse practitioners, physician assistants in certain settings), hospitals, and dentists. The MEHRIP has been an important driver of high EHR adoption rates among providers eligible for incentives. Oregon's Medicaid EHR Incentive Program has paid 128 behavioral health providers, and 32 new behavioral health providers have attested in program year 2016. The program runs through 2021, but is now closed to new enrollees.

Similarly, there are financial challenges to participating in health information exchange. To date, many HIE efforts support clinic use without ongoing costs (such as regional HIEs and PreManage), but initial costs to launch a connection to an HIE effort can be prohibitive, as well as the need to have sufficient IT staff or support to manage the connection and use of HIE.

HIE Onboarding Program (in development)

The Health Information Exchange (HIE) Onboarding program will help connect (onboard) key Oregon Medicaid providers to community-based HIEs that provide meaningful HIE opportunities and play a vital role for Medicaid in their communities. Connecting safety-net behavioral health providers to HIE (Community Mental Health Programs, Certified Community Behavioral Health Centers, behavioral health homes, Assertive Community Treatment (ACT) teams, and mobile crisis teams) will be a high priority in the first phase of the program. The program will also partially offset certain provider-side costs of HIE onboarding for providers who face barriers. The program is expected to launch in 2018.

Recommendation 2: Provide technical assistance and learning opportunities to support EHR adoption and effective use and HIE participation, as well as privacy and security needs, such as consent management.

Behavioral health agencies who are active participants in a regional or private HIE, or users of PreManage may have opportunities for technical assistance and learning opportunities associated with that HIE effort. However the majority of behavioral health agencies are not currently participating in these tools yet. Expanding participation in these efforts will help spread the reach of these learning opportunities, but agencies could benefit from additional assistance and learning opportunities.

In terms of privacy and consent concerns, OHA has engaged in providing resources to stakeholders related to behavioral health information sharing, and has additional efforts underway. Additional opportunities will be explored to support learning and assistance for behavioral health agencies.

Common Consent Model and Behavioral Health Information Sharing Provider Toolkit (in development)

Given federal restrictions (under 42 CFR Part 2 – see page 18), there is a significant need for clarity about what behavioral health information may be shared lawfully.

Through federal Office of the National Coordinator for HIT cooperative agreement funding, Reliance eHealth Collaborative (an Oregon HIE) worked to address barriers to information sharing and care coordination across settings, particularly for behavioral health data, by developing a common consent model based on legal analysis done by a neutral law firm, that addresses many of the privacy and security issues related to 42 CFR Part 2. As part of the federal funded work, Reliance hosted a Behavioral Health Forum in summer 2017 to share the results of their work and convene stakeholders to learn from each other and share needs. Many attendees indicated the value of coming together around this work and that there were few venues for learning opportunities. Resources from the forum are currently available on Reliance's website: http://reliancehie.org/behavioralhealthforum/.

OHA's Behavioral Health Information Sharing Advisory Group provided several webinars and other resources to Oregon stakeholders in 2015/2016. Staff are currently preparing a Provider Toolkit which will contain sample consent forms based on the Reliance work on a common

consent model as well as information sheets and training materials that behavioral health providers can use to train their staff. To be made available in 2018. See resources on OHA's current Behavioral Health Information Sharing Advisory Group website: http://www.oregon.gov/oha/HPA/CSI-BHP/Pages/Behavioral-Health-Info.aspx.

Block Grant Technical Assistance (in development)

OHA has committed to setting aside SAMHSA Block Grant funds to provide technical assistance to support behavioral health HIT/HIE. The support provided will be informed by individual agency needs and statewide strategy. These services are expected to become available in 2018.

Oregon Medicaid Meaningful Use Technical Assistance Program (OMMUTAP)

OHA offers no-cost technical assistance to providers adopting and using EHRs via OMMUTAP. However, due to federal funding restrictions, the program is not available to providers who are not meet the EHRIP eligible provider criteria. Approximately five behavioral health agencies are currently participating in OMMUTAP. This program ends May 2019.

Recommendation 3: Support agencies' opportunities for collaboration and shared learning with other behavioral health agencies around EHR adoption and effective use, HIE participation, and privacy and security issues.

Some interviewees reported participation in consortiums available to community health centers, often specific to an EHR vendor's product. In some cases, HIE efforts may bring behavioral health providers together to learn from each other – for example, the EDIE Utility hosts a PreManage learning collaborative for behavioral health providers who use the system. Interviewees also reported several informal collaborative efforts around HIT/HIE. Efforts ranged from discussion in regular cross-agency meetings to sharing of IT staff resources with agencies that lack in-house IT staff. OHA will seek opportunities to encourage and promote such efforts to facilitate shared learning across agencies on various topics related to HIT/HIE including from participants in the CCBHC work.

Certified Community Behavioral Health Clinic (CCBHC) Demonstration Program

Agencies participating in the CCBHC Demonstration Program are blazing new trails for Oregon's behavioral health system. Many lessons will be learned and shared, including the role HIT and HIE play in expanding and improving care, integrating and coordinating care, and tracking patient progress and outcomes.

Recommendation 4: Ensure behavioral health agencies can take advantage of statewide robust HIT/HIE efforts, and that these efforts address needs of behavioral health agencies, clinicians, patients, and other stakeholders.

EDIE/PreManage

The Emergency Department Information Exchange (EDIE) is a web-based application that allows Emergency Departments (EDs) to identify patients with complex care needs who frequently use the emergency room for their care. PreManage expands access to EDIE data to other users such as health plans, Coordinated Care Organizations (CCOs), clinics and other care coordination partners to improve coordination of patient care. Behavioral health providers can use PreManage to identify when they need to follow up with a client after hospitalization or emergency room visit, share recommendations with ED providers and to provide better care to

patients who have been seen in the ED. Some more sophisticated agencies are using extracts of their clients' EDIE data to incorporate into their data analytics, risk modeling, and quality improvement analytics.

As of October 2017, 19 mental health/behavioral health clinics and 15 Assertive Community Treatment teams are using PreManage, and efforts are underway to increase participation. Clinics and ACT teams use of PreManage is funded either by a CCO or by OHA. Work is underway to pilot EDIE for mobile crisis units. The EDIE Utility has sponsored learning collaboratives, including an online learning community and a behavioral health-focused PreManage learning collaborative meeting. A recent evaluation showed considerable value by users and reduced ED utilization by some high-utilizers when a care recommendation in EDIE was used. See the full evaluation here: http://www.orhealthleadershipcouncil.org/edie/.

Prescription Drug Monitoring Program (PDMP) Gateway

OHA and other stakeholders have worked to improve access to the state's Prescription Drug Monitoring Program specialized registry, which contains information on controlled substances/opioid prescription fills. A new HIT gateway service will allow EHRs and other HIT systems, including HIEs and EDIE, to connect directly to the PDMP database and provide actionable data within a prescriber's workflow. Although most behavioral health agencies are not prescribers of controlled substances, improving prescriber access to PDMP data can support better prescribing practices and is a key support for addressing the opioid crisis.

HIE Network of Networks (in development)

HITOC's updated Strategic Plan for HIT/HIE envisions a web of interconnected HIEs and other networks, so that providers and patients can share information not just among EHRs but among all Oregon HIEs, and access other high-value data sources. Incorporating behavioral health needs and perspectives in developing and implementing a Network of Networks in Oregon will be critical.

HIT Commons

The HIT Commons is a public/ private partnership to coordinate investments in health IT, leverage funding opportunities, and advance health information exchange across the state. HIT Commons will govern the EDIE Utility, the PDMP Gateway statewide subscription, and will explore the development of the HIE Network of Networks. In expanding the Governance role from its EDIE Utility origins, the Board make-up was expanded to add a behavioral health, dental, and county public health spot on the 17-member Board. The new HIT Commons Board is expected to launch in early 2018.

Recommendation 5: Seek opportunities to reduce reporting burden or otherwise provide support for behavioral health agencies' reporting requirements

As alternative payment models, performance metrics, and accountability requirements evolve, behavioral health will need support to be successful in their efforts to advance in these areas. Rather than increase reporting, OHA will seek opportunities to align or reduce reporting burden or provide other support related to reporting.

Clinical Quality Metrics Registry (in development)

Behavioral health providers participating in the Medicaid EHR Incentive Program and other pay for performance programs may be required to report clinical quality metrics. Oregon's Clinical Quality Metrics Registry (CQMR) will collect, aggregate, and provide clinical quality metrics data to meet program requirements and achieve efficiencies for provider reporting. Initially, the CQMR will support the Medicaid EHR Incentive Program and the Coordinated Care Organization (CCO) incentive measures that are EHR-based. Over time, other quality reporting programs could use the CQMR as well, which will support OHA's goal of streamlining and aligning quality metric reporting requirements and reducing provider burden.

Additional Considerations

Continue efforts to engage behavioral health agencies and conduct future environmental scan work

OHA will continue to monitor the changing BH HIT/HIE environment and flesh out the findings of the current Behavioral Health HIT/HIE Scan, including the issue of limited EHR options for many behavioral health agencies. OHA will also explore opportunities to incorporate gathering information about HIT into other regular data collection or reporting and to increase the ability for regular monitoring of progress or barriers with HIT/HIE. Continuing to include behavioral health representation and involvement in HIT/HIE stakeholder workgroups or committees, to ensure behavioral health perspectives are included in future work.

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Appendix A: Crosswalk of Recommendations with Conclusions and Identified Needs

Recommendations:	1. Financial support	2. TA and learning opportunities	3. Collaboration & shared learning	4. HIT/HIE that addresses BH needs	6. Support for reporting requirements
Current Strategies:	MEHRIP, HIE Onboarding Program	OMMUTAP, Block Grant funded TA	Informal collaborations currently occurring	EDIE/PreManage, PDMP Gateway, HIE Onboarding Program, Network of Networks, HIT Commons	
Conclusion 1: Most behavioral health agencies could benefit from additional HIT support.					
Need 1a: HIT tools that serve BH specific needs					
Need 1b: Financial support & TA for EHRs					
Need 1c: Collaboration & shared learning re: EHRs					
Conclusion 2: Behavioral health agencies need HIE opportunities, which are presently nascent and evolving.					
Need 2a: HIE tools that can serve BH specific needs					
Need 2b: Financial support & TA for HIE participation					
Need 2c: Robust HIT to support participation in HIE					
Conclusion 3: Behavioral health stakeholders need more support and clarity about privacy and security of health information.					
Need 3a: Guidance re: information sharing allowed					
Need 3b: P&S tools and capabilities integrated into HIT					
Conclusion 4: Behavioral health agencies could benefit from resources and support for data analytics.					
Need 4a: Robust HIT to support analytics & reporting					
Need 4b: Data analytic tools & capabilities specific to BH					
Need 4c: Consolidated reporting requirements					

Appendix B: Table of Policy Context Topics, Description and Impact, and Links for Additional Information

Policy context topic	Description and impact
Oregon Health Policy Board's Action Plan for Health	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, and 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. https://apps.state.or.us/Forms/Served/le9963.pdf
Behavioral Health Collaborative	In 2016, OHA convened a diverse group of nearly 50 individuals from across the state representing every part of the behavioral health system called the Behavioral Health Collaborative (BHC) 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...', which includes a series of action items targeted to improve behavioral health information sharing and reducing barriers to data access. http://www.oregon.gov/oha/HPA/CSI-BHP/Pages/ Behavioral-Health-Collaborative.aspx
Health Information Technology Oversight Council (HITOC)	Oregon's legislature charged HITOC with overseeing the Oregon HIT Program, monitoring the HIT landscape in Oregon, 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. http://www.oregon.gov/oha/HPA/OHIT-HITOC/Pages/About-Us.aspx
HIT Oversight Council (HITOC) and Oregon's Strategic Plan for HIT/HIE (2017-2020)	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. http://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/ OHA%209920%20Health%20IT%20Final.pdf
Certified Community Behavioral Health Clinic (CCBHC) Demonstration Program	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-base 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. http://www.oregon.gov/oha/HPA/CSI-BHP/Pages/Community-BH-Clinics.aspx

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Appendix C: Oregon HIT Program Descriptions

Office of Health Information Technology

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.

Vision and Goals for HIT:

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 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.

Partnerships

HIT Commons

The Oregon Health Leadership Council (OHLC) and OHA, along with many stakeholders, are creating a public/private HIT governance partnership for Oregon known as the HIT Commons. A shared governance model will help accelerate HIT adoption and use across Oregon, leverage public and private investments, expand access to high-value data sources (see EDIE and PDMP Gateway below), and advance a network of networks approach to health information exchange. ***Launching 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 visit the emergency department frequently, with the goal of reducing avoidable hospital utilization and improving health outcomes. EDIE Utility is a public/private partnership to fund and govern the EDIE infrastructure. ***EDIE Utility will be 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.

Program status, November 2017:

- **PreManage:** Nearly all CCOs, many commercial health plans, and over 200 physical, behavioral, and dental clinics are participating.
- **PDMP Gateway:** Launched summer 2017. Regional HIEs Reliance eHealth Collaborative and IHN-CCO's Regional Health Information Collaborative are in process of launching. EDIE is rolling to Oregon EDs – Asante is first to launch.
- **Medicaid and Medicare EHR Incentive Programs and OMMUTAP:** More than 7,800 Oregon providers and 61 hospitals have received about $494 million through the Medicaid or Medicare EHR incentive programs. OHA launched OMMUTAP technical assistance in 2016 through a contract with OCHIN and has enrolled more than 1,300 providers at 310 clinics.
- **Flat File Directory for Direct secure messaging:** contains more than 15,000 addresses across 24 entities who represent more than 630 unique health care organizations.

PDMP Gateway: Electronic access to Prescription Drug Monitoring Program

Authorized Oregon prescribers, pharmacists and their delegates can now access Prescription Drug Monitoring Program (PDMP) data within their electronic workflow via the PDMP Gateway. Access to accurate and timely PDMP information at the point of care can help inform clinical decisions and improve patient care. OHA launched the PDMP Gateway in summer 2017.

- Currently, organizations pay an annual PDMP Gateway vendor fee to participate. A statewide subscription is planned for 2018, which will leverage significant federal match, state funds, and private contributions, under the HIT Commons.

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, and is commonly used by providers and hospitals 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.

In Development

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 amongst 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 the onboarding of long-term services and supports, social services and other critical Medicaid providers. ***Launching in 2018.***

Oregon Common Credentialing Program

The Oregon Common Credentialing Program will provide a web-based system to improve efficiencies and relieve burden related to practitioner credentialing. The program will collect and verify health care practitioner credentialing information, and will be used by credentialing organizations for the purposes of credentialing and recredentialing practitioners. Participation in the program is legislatively mandated and will be funded via fees. ***Launching in 2018.***

Provider Directory

This state-level provider directory will be a source of accurate healthcare 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 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 2018.***

- **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.
- **The Oregon Common Credentialing Program** will streamline and centralize credentialing information to create efficiencies for an estimated 55,000 practitioners across Oregon and more than 300 credentialing organizations.
- **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.
- **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.

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. ***Launching in 2018.***