



BEHAVIORAL HEALTH SURVEY REPORT

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Key Findings

The Illinois Office of Health Information Technology received the BHIP grant to examine the readiness of behavioral health organizations in the state of Illinois to participate in health information exchange. This grant sponsored a series of events, including two state wide surveys, state wide focus groups and 6 demonstration projects focused around behavioral health information exchange. Analysis of these activities identified several key findings:

- EHR awareness among behavioral health providing organization is high. Results of both surveys suggested that 70% or more organizations were on an EHR or planning to implement within the next several years
- Most behavioral health organizations have at least nominal IT support, but only a fraction reported having a full time director of IT or CIO, suggesting that many interested sites may lack IT leadership necessary for successful adoption of EHR and participation in HIE activities
- Consistent with the national study in 2009, and the lower level of IT leadership, 65% of organizations were dedicating 2% or less of their budget to HIT needs (national average for general health care is 3.5%) suggesting that while aware of the importance of EHR adoption, behavioral health organizations may not be dedicating (or may not have) enough funds to be successful.
- There is a high degree of interest in exchanging data but relatively low knowledge amongst the leadership people who participated in the surveys and the summits on how to do this. Methods and Data Validity

BHO HIT Prep Survey Methodology

This survey was developed using the 2009 Behavioral Health/Human Services Information Systems survey which assessed information technology (IT) utilization, expenditures, service delivery practices and attitudinal factors in the behavioral health community nationwide¹. The survey was revised and updated to include additional questions about EHR adoption, Meaningful Use awareness and readiness, and health information exchange. The final survey was composed of 54 questions and was administered on line using the web-based SurveyMonkey platform. Respondents accessed the survey by clicking on a link in an electronic invitation to participate in the survey. The survey was launched on February 15, 2012 and closed on March 30, 2012 (IS THIS TRUE? THIS IS BASED ON DATES IN THE DATA SET).

Representatives from a total of 700 behavioral health organizations were invited to participate in the survey. This included all state-funded and licensed behavioral health providers (n=527) as well as members of the Illinois Psychiatric Society that were not included in the state-funded list (n=163). A total of 128 (18.2%) of the invitees responded to the survey. The distribution of respondents across the state of Illinois can be seen in Figure 2.

¹ <http://www.satva.org/documents/InformationSystemsSurveyReportFinal.pdf>
Last updated 2/28/2013

The use of web-based technology eliminated the need for manual data entry and reduced the potential for data entry errors since information entered online was transmitted directly to the database. Organization name and address information was collected for the survey and used to assess results on a regional basis. Survey responses for each question were analyzed by overall sample, as well as by whether the organization provided mental health services, substance abuse treatment services or both. The information was summarized using descriptive statistics only. No inferential statistics were applied to the data.

Trends and Micro Trends

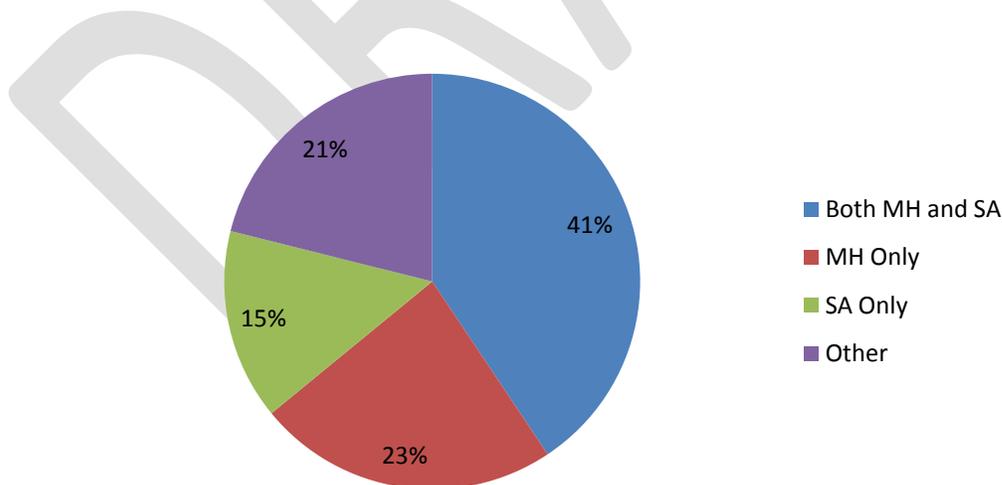
Demographics of Survey Participants

To better understand the makeup of the behavioral health community, the first part of the survey examined the general demographics of the organizations, including their location, primary scope of practice, size of organization and licenses held by the participants.

Services Provided

The participants were categorized by the behavioral health services they provided: Substance Abuse Treatment (SA Only), Mental Health Treatment (MH Only), Mental Health and Substance Abuse Treatment (MH and SA) or Other if they participated in the survey but did not indicate that they provided any of the 19 pre-defined options. The chart in Figure 1 shows the percentage of responses based on the primary service categories the organization identified with.

Figure 1: Breakdown of BHO Survey Participants by Service Sector (n=128)



Organizations were also asked to indicate whether they provided on-site primary medical care services in addition to behavioral health services. The majority (62%) provided only behavioral health services, but a significant percentage did provide primary medical care. When this was examined by sector, a similar

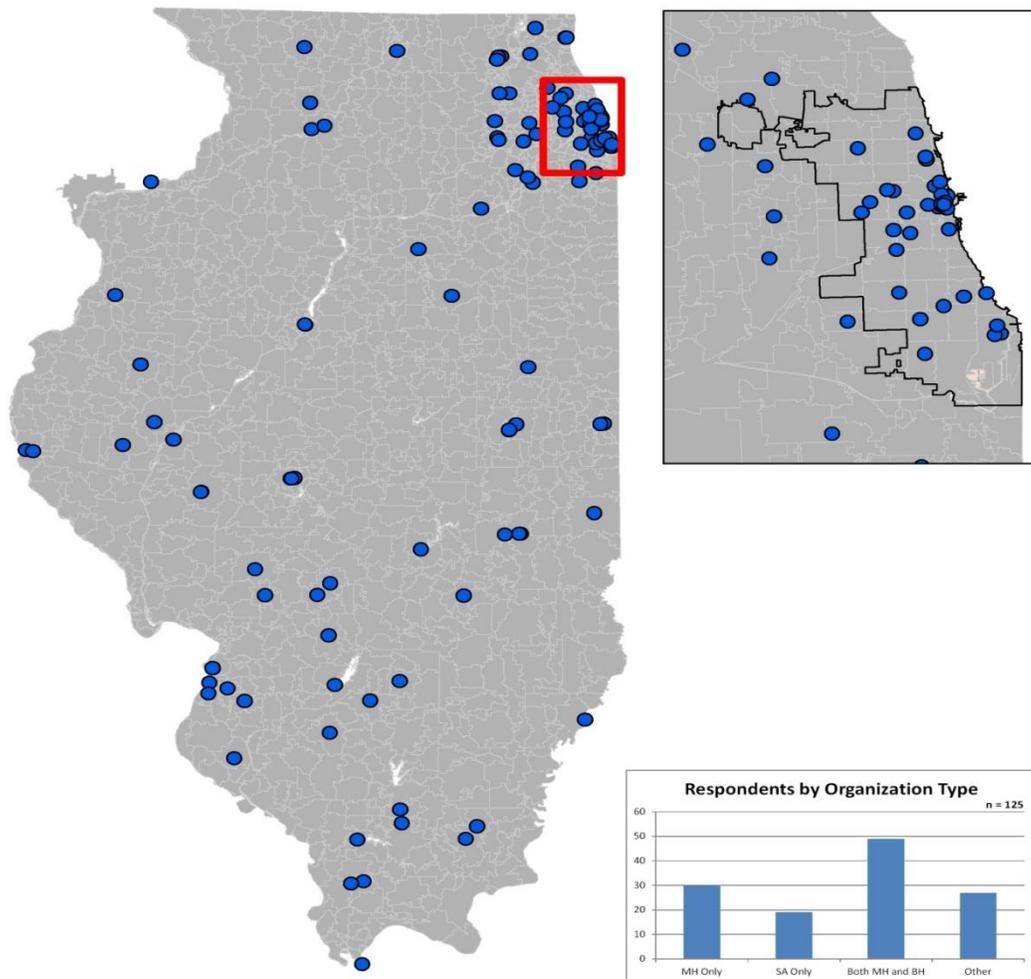
proportion was observed regardless of sector examined. These results suggest that a significant percentage of organizations may need to implement internal and external care coordination/data sharing workflows.

Geography and Setting

The survey included urban and non-urban participants: 51% of organizations provide services in an urban setting, 33% provide services in a rural setting and 16% provide services in both settings. There was representation from throughout Illinois. The map in Figure 2 shows the geographic distribution of the survey participants.

Figure 2: BHO HIT Prep Survey Respondent Distribution throughout Illinois (n=125)

BHO HIT Prep Survey Respondents

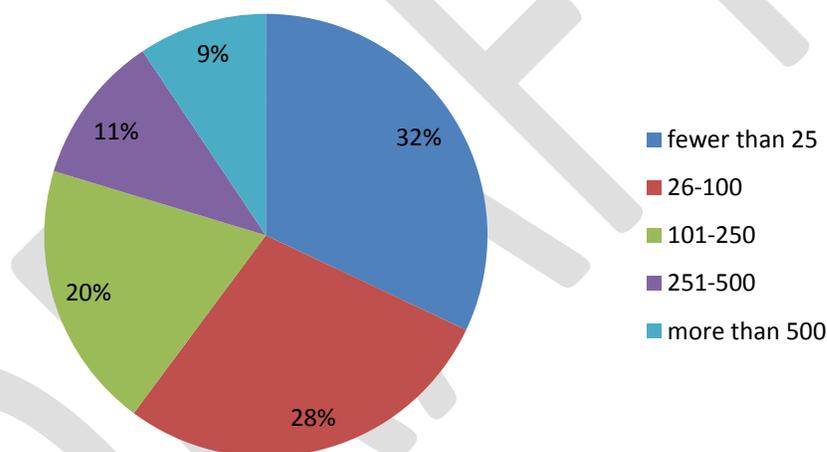


The largest group of participants (41%) supplied both MH and SA services, with the next largest group being standalone MH services (23%). Overall, 64% of the organizations provided some form of MH service and 56% provided some form of SA services suggesting that the concerns of both sectors were well represented in the survey.

Size and Tax Status

The survey also addressed the size and tax status of the organizations. 87% of those surveyed were not-for-profit or government run organizations and 70% of them operated 5 or fewer sites. The staffing numbers complete the picture for organization size. 32% had 25 or fewer full time staff equivalents (FTEs) while 60% had 100 or less FTE (see Figure 3 for full breakdown). Put together, this suggests that many organizations may have few sites but relatively sizable staffs to prepare to transition to electronic tools.

Figure 3: Full Time Staff Equivalents in Illinois Behavioral Health Organizations (n=128)



Income and Income Sources for Behavioral Health Organizations

To get a better picture of the preparation for HIT adoption, the BHO survey asked questions about the financial demographics of the organizations. As shown in Figure 4, 71% of the organizations who responded had an annual operating budget of \$1M or more, with 44% having an operating budget of greater than \$5M.

The survey also asked organizations to indicate their primary funding sources. They were allowed to pick one or more categories of funding. The three most common sources were self-pay, Medicaid and grants, with the majority of revenues coming from Medicaid (70 out of 128 organizations indicated that 10-90% of their revenues were from Medicaid) while 79 out of 128 organizations reported only 1-10% of their revenues from self-pay. This suggests that even though all BH organizations had self-paying clients, they don't generate most

of their revenues from this patient population. 47 out of 128 organizations also reported that 1-10% of their revenues from private insurance. Taken together, this data suggests that Medicaid is the single largest payer for BH services in the organizations surveyed and is the payer that would stand to benefit the most from HIT adoption and data sharing.

Figure 4: Total Yearly Organizational Operating Budget (n=128)

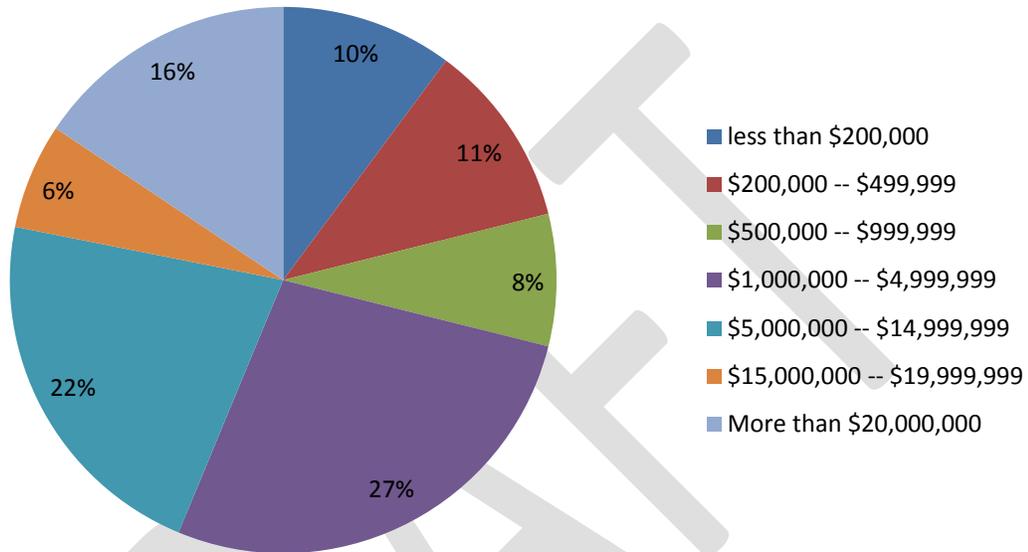
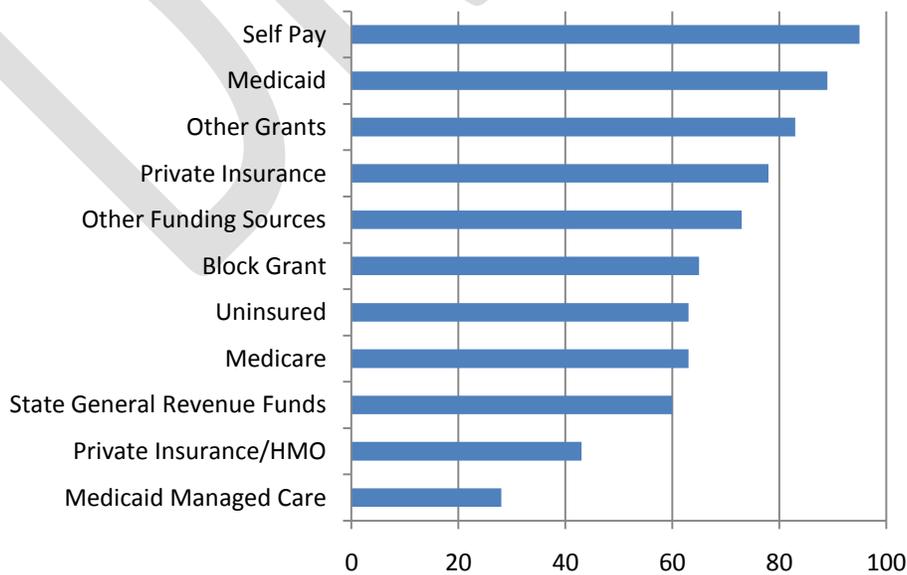


Figure 5: Funding Sources for Illinois Behavioral Health Organizations



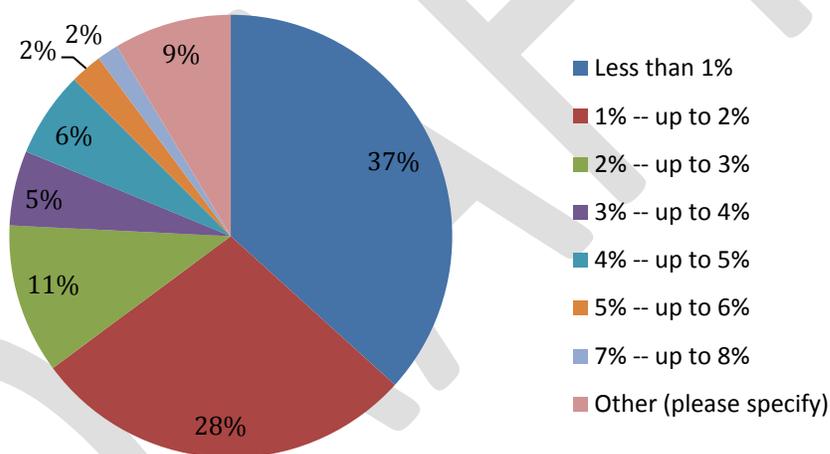
Staffing and Financial Support for HIT Adoption

To evaluate the financial and human resource readiness for HIT adoption, survey also addressed the amount of the annual budget allocated to HIT and the level of IT support in the organization.

Financial Support

Organizations were asked to indicate what percentage of their annual operating budget they were allocating to HIT. 65% indicated 2% or less, with almost 40% indicating 1% or less (see Figure 6). Given that the national average for spending in this area by medical organizations is almost 3.5%¹, this suggests that BH organizations may not have good estimates of the costs of HITA, may not be financially ready for HIT adoption or that HIT adoption may be considered a low priority by senior management.

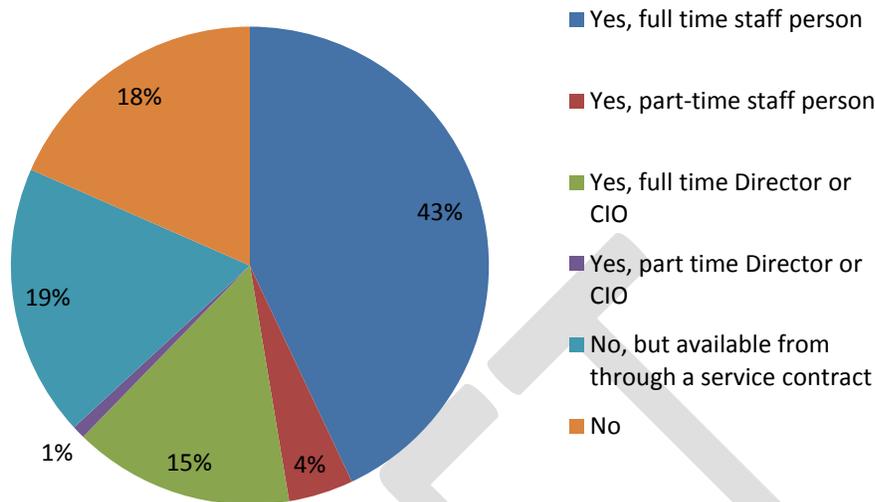
Figure 6: Percentage of Annual Operating Budget Allocated to HIT (n=128)



IT Staffing

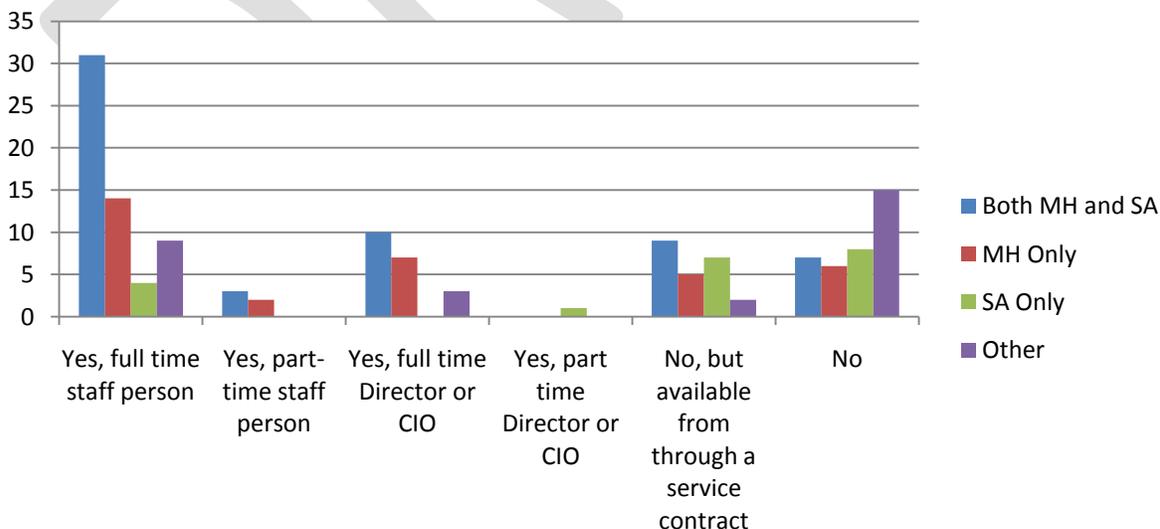
The survey also asked organizations to identify whether or not they had IT staffing and the type of staffing they employed or had access to. 63% of organizations had some onsite IT personnel and another 19% indicated that they could contract for it. However, only 15% reported having a full time director of IT or a CIO, suggesting that while IT support may exist, they may not be strong IT leadership at most sites to help drive HIT adoption (see Figure 7 for a full breakdown of the responses).

Figure 7: Onsite HIT Staff at Illinois Behavioral Health Organizations (n=143)



When IT staffing levels were examined across the BH specialty types, those organizations providing both MH and SA services were most likely to have a full time staff person or an IT Director/CIO, while SA only organizations were most likely to have no staffing or staffing only available through contracting, suggesting that they may be less ready from a staffing perspective to adopt EHR and data exchange technologies and are unlikely to have a leadership person available to direct the program. A full examination of this data can be found in Figure 8.

Figure 8: Onsite IT Staff by BH Organization Type (n=143)

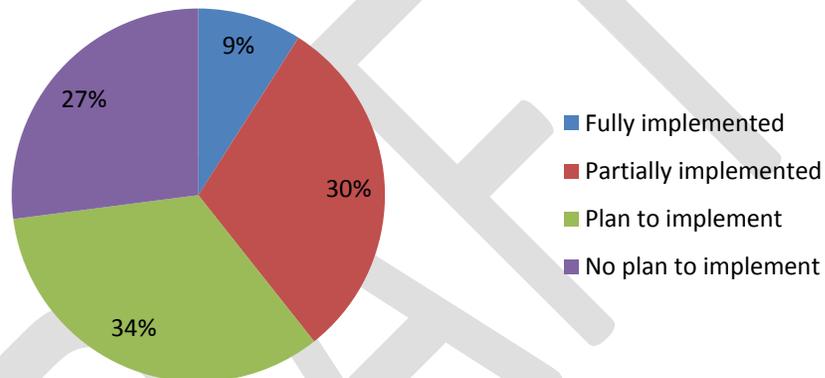


EHR Implementation

EHR Adoption and Implementation Planning

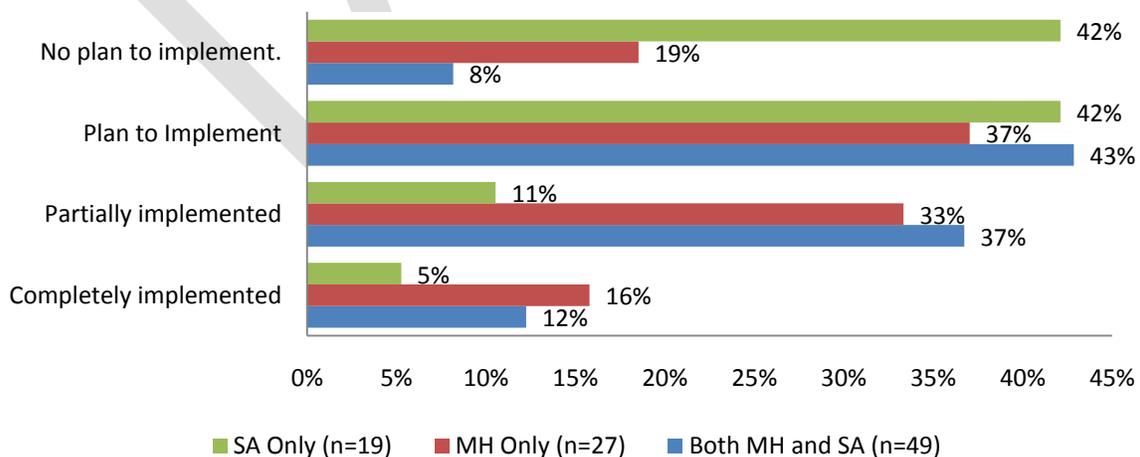
All the organizations who participated in the survey were asked to provide information about whether they had implemented an EHR and what the status of the implementation was. The progress in this area is very encouraging. As shown in Figure 9, taken together almost 40% of the organizations had fully implemented or were in the process of implementing an EHR and another 34% indicated they were planning to implement. Less than 30% had no plans to implement. This suggests that the BH community as a whole is aware of EHR technology and is convinced of its value.

Figure 9: EHR Implementation Plans of BH Organizations (n=122)



To understand better the level of EHR implementation across the spectrum of BH service provider types, this data was analyzed by BH sector. The results are shown in Figure 10. In this analysis, the “other” group was eliminated to focus on the more specific provider types.

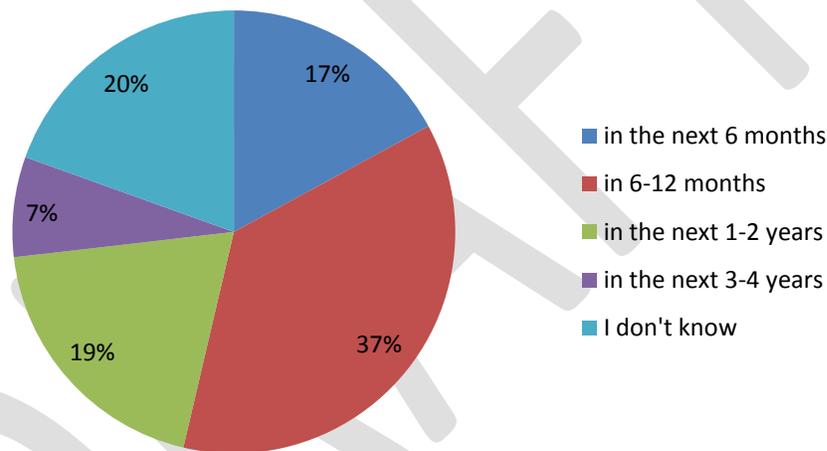
Figure 10: EHR Implementation by BH Organization Type



While all organization types were represented across the full spectrum of implementation from completely implemented to no plans to implement, the proportion of each type in each level of implementation plans varied. 49% of MH and SA and MH only organizations had partially or completely implemented, compared to 16% of the SA only group. There were similar proportions of organizations in all three subcategories planning to implement. Finally, 42% of the SA only organizations had no plans to implement an EHR at all, compared to 19% of the MH only organizations and only 8% of the organizations that provided MH and SA services. This data demonstrates that SA only organizations are less likely to have implemented an EHR and are more likely to have no plans to adopt an EHR in the future, suggesting that there may be challenges to coordinating care for the patients who seek treatment with these organizations.

Those who were planning to implement an EHR were asked to provide information about when they planned to do so. The results are described in Figure 11.

Figure 11: Implementation Timeline for BH Organizations Planning to Implement an EHR (n=41)



54% of those planning to implement were planning to do so in the next 12 months, and another 26% plan to implement in 1 to 4 years. This suggests that the majority of BH organizations who participated in this survey will have implemented an EHR by 2017.

Of those organizations implementing an EHR, 93% were not replacing an existing EHR (n=40) and 88% indicated that they were implementing an EHR for the first time (n=43).

EHR Implementation Barriers and Drivers

Finally, the participating organizations were asked to indicate why they were implementing an EHR as well as those things that were barriers to EHR implementation. To understand the drivers for EHR adoption, the participating organizations were provided 6 pre-defined options and were allowed to select any that applied. The results can be seen in Figure 12. Generally speaking, the respondents indicated that all the options were relevant, and were expecting the EHR to help them improve most operational aspects of their organization,

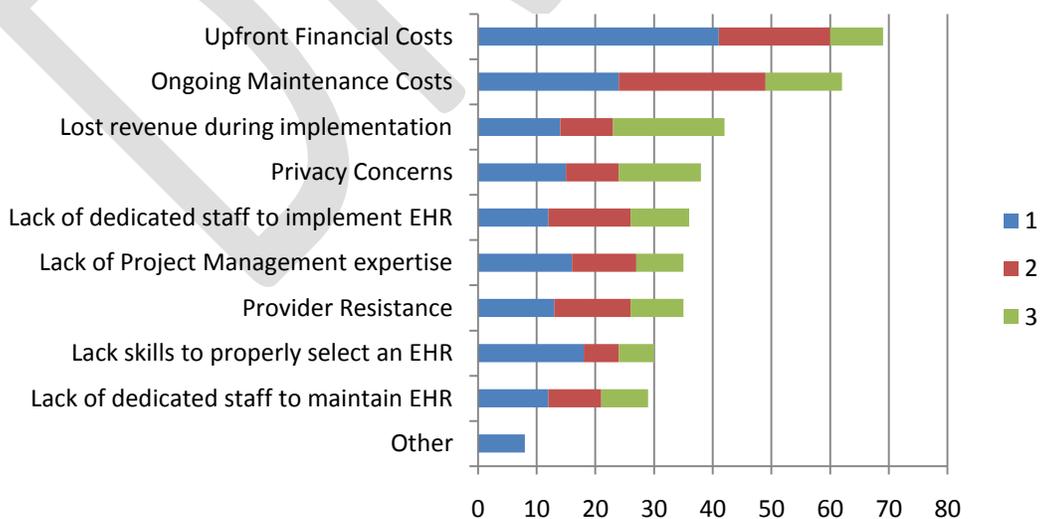
including overall operations, data capture and reporting, care coordination, organizational growth, billing and retaining a competitive advantage in the marketplace.

Figure 12: Expected Benefits of EHR Adoption by BH Organizations (n=XX)



Organizations were provided with a fixed list of possible barriers (Upfront Financial Costs, Ongoing Maintenance Costs, Lost revenue during implementation, Lack skills to properly select an EHR, Lack of dedicated staff to implement EHR, Lack of Project Management expertise, Lack of dedicated staff to maintain EHR, Provider Resistance, Privacy Concerns, Other) and asked to rank those barriers in order of significance to their organization (with 1 being the most important, 7 being the least important). The results can be seen in Figure 13, which shows the how many respondents ranked each barrier in their top 3 concerns.

Figure 13: Barriers to EHR Adoption and Implementation for BH Organizations in Illinois (n=XXX)



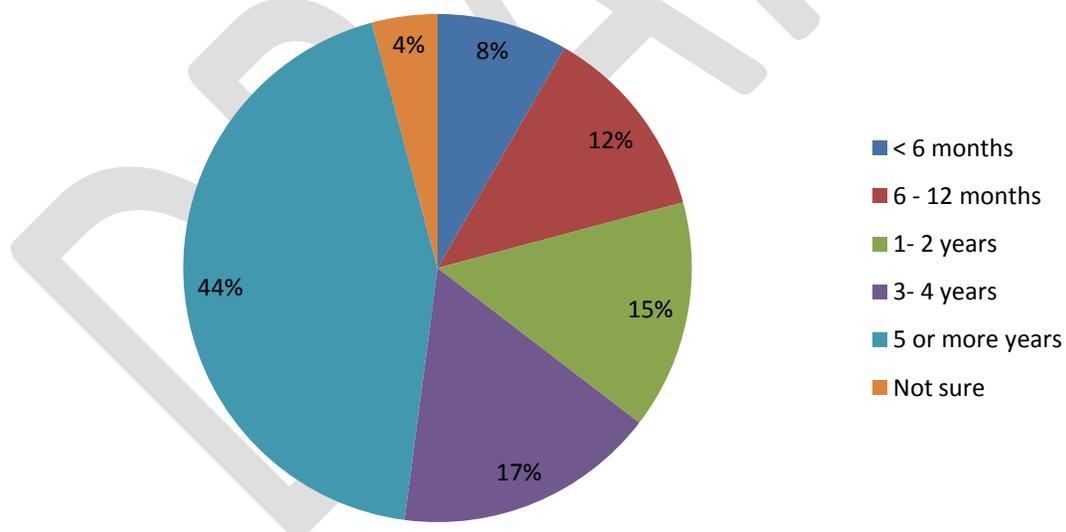
Upfront financial costs and ongoing maintenance costs were clearly seen as the biggest barriers, consistent with the overall low percentage of the operational budgets that the organizations were allocated on a yearly basis for HIT.

EHR Use

Those organizations already using an EHR (n=48) were asked to provide more information about their EHR system and how long they had been using it. All respondents were asked to provide the name of the EHR they used. No one EHR system dominated, suggesting a diverse EHR ecosystem amongst BH providers in Illinois. In addition, when asked how their EHR was hosted, 79% of respondents indicated that they had an internally hosted EHR, 13% had an externally hosted web-based EHR, and 4% had an externally hosted non-web-based system while 4% did not know where their EHR was hosted.

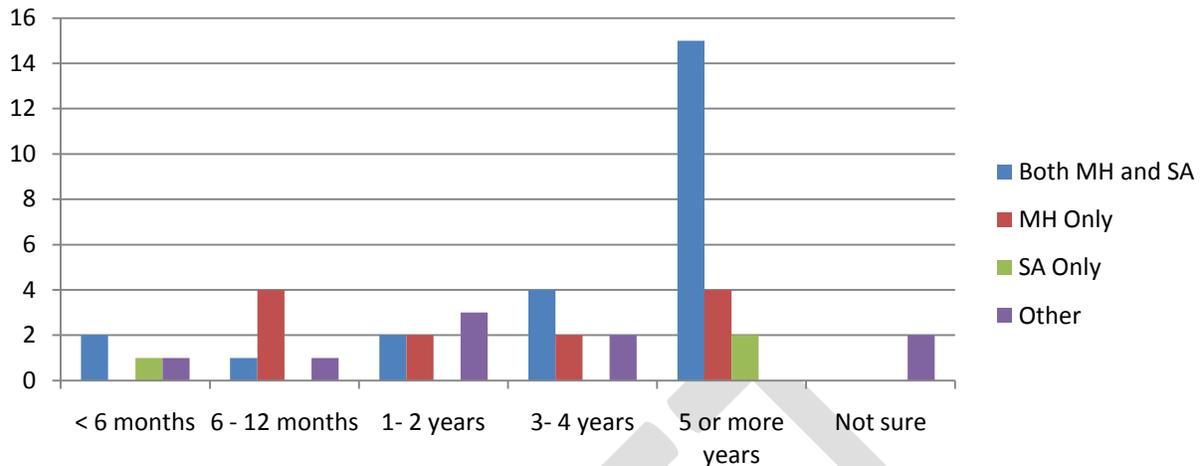
When asked how long they had been “live” on their EHR, 76% indicated that they had been live on their EHR for a year or more, and 44% had been live for more than 5 years. The results are shown in Figure 14. This data suggests that amongst a core group of these organizations there is significant experience using an EHR.

Figure 14: Number of Years Since Go Live on their EHR (n=48)



To better understand which types of BH organizations had been live on their EHR systems the longest, the data was further subset by the organization classification. Of those that had been using for 5 years or more (n=21), 75% of the organizations in that category (n=15) were both MH and SA providing organizations. This group of organizations may contain a group of “super users” that could be tapped to develop best practices for adoption and maintenance for those organizations that are planning to implement or are still early in the implementation process. This data can be seen in Figure 15.

Figure 15: Time Since Go Live on EHR Broken out by BH Organization Type



Data Sharing, Care Coordination and HIE

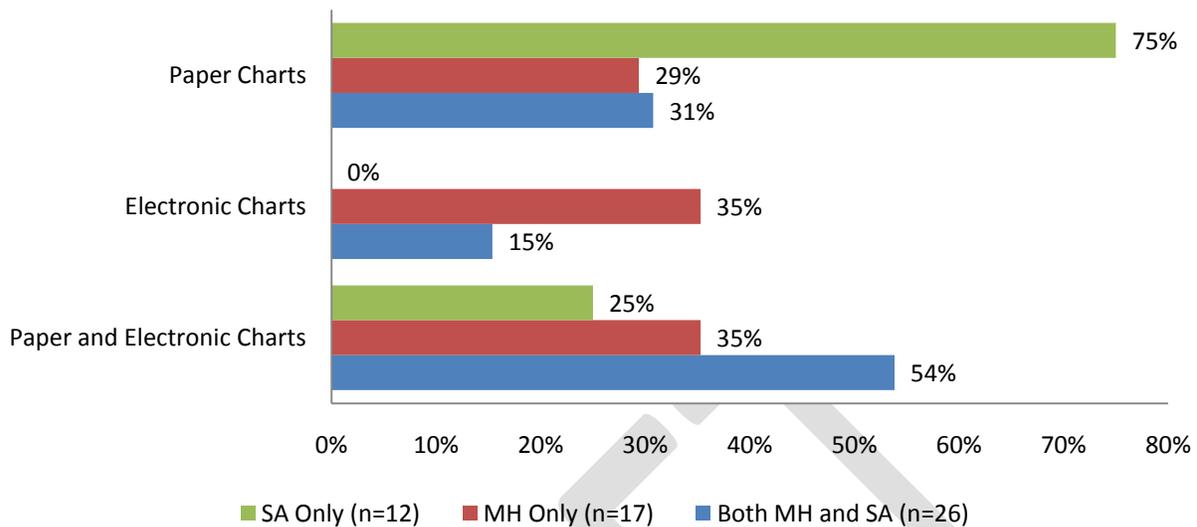
Care coordination is considered a significant driver for EHR use across the country and will be a focus for accountable care organizations and patient centered medical home initiatives. As documented in the demographics section, 38% of behavioral health organizations also provide primary medical care services and it is anticipated that many more will need to coordinate care with local primary medical care providers in their area.

Record Format and Local Integration

Survey participants were asked to indicate what format their primary care records were in. Of the 68 participants that answered this question, 41% indicated that they used a combination of paper and electronic charts, 38% used paper charts exclusively and 21% used electronic charts exclusively – thus 62% of these organizations are using electronic records at some level. The total number of respondents answering this question is higher than the number of organizations indicating that they had a primary medical care program suggesting that some of these respondents are considering their primary BH sector to constitute primary care for the purposes of this question.

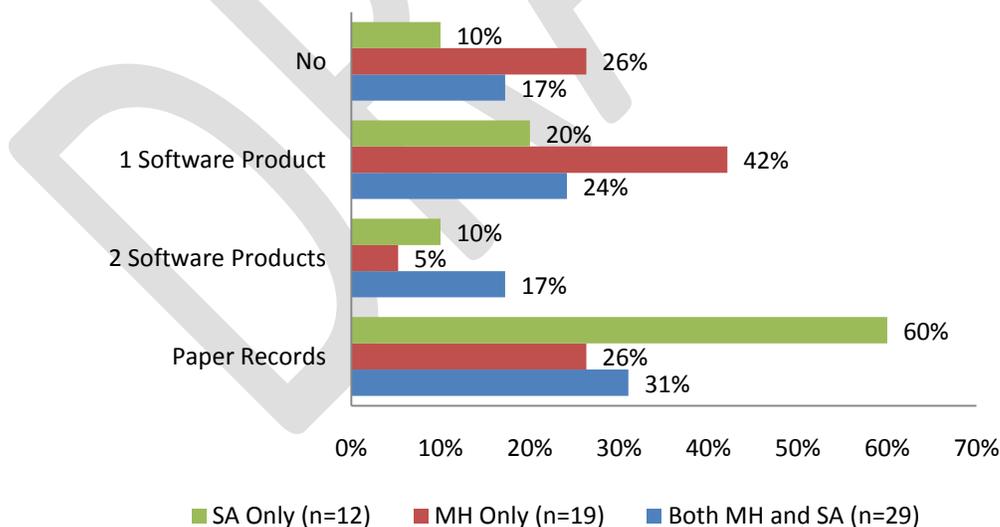
The data was further segmented by service sector and is shown in Figure 16. Approximately 70% of organizations providing both MH and SA services or only MH services indicated using electronic records to some degree for their primary care records, while 75% of SA only providers indicated that they were working only with paper records. This is consistent with data discussed in the EHR adoption section of this report that indicates that SA only providers are less likely to have adopted or to be planning to adopt an EHR.

Figure 16: Patient Record Format by BH Service Sector (n=68)



Organizations were then asked if their BH and medical care records were integrated, and, if so, how. The results are shown in Figure 17. 60% of SA only providers integrated their records on paper, while approximately 30% of MH and MH and SA providers did the same. When it came to software based integration, there was less variation: 47% of MH providers, 41% of MH and SA providers and 30% of SA only providers use this mechanism.

Figure 17: Type of Integration of BH and Primary Medical Care Records for BH Organizations

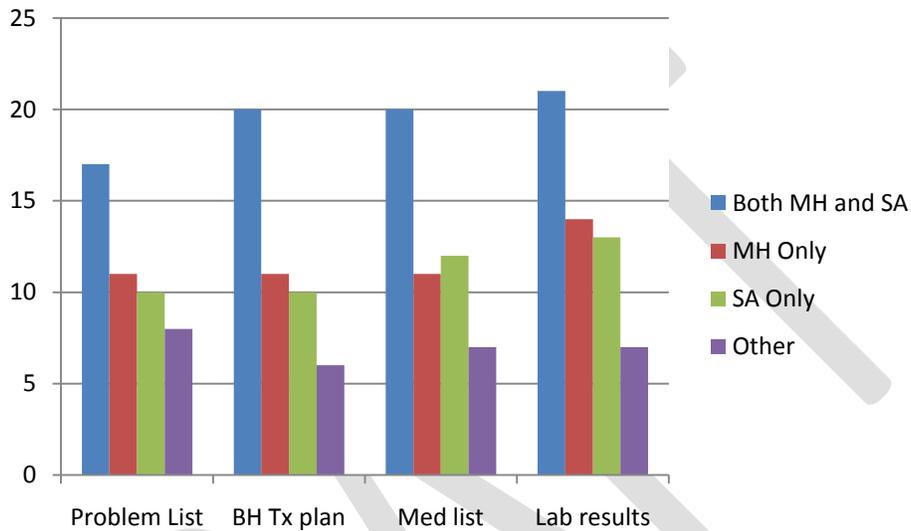


Data Types Shared

Survey respondents with medical and behavioral health services were asked to indicate whether there was data sharing between providers in the different services (regardless of whether they used paper or electronic

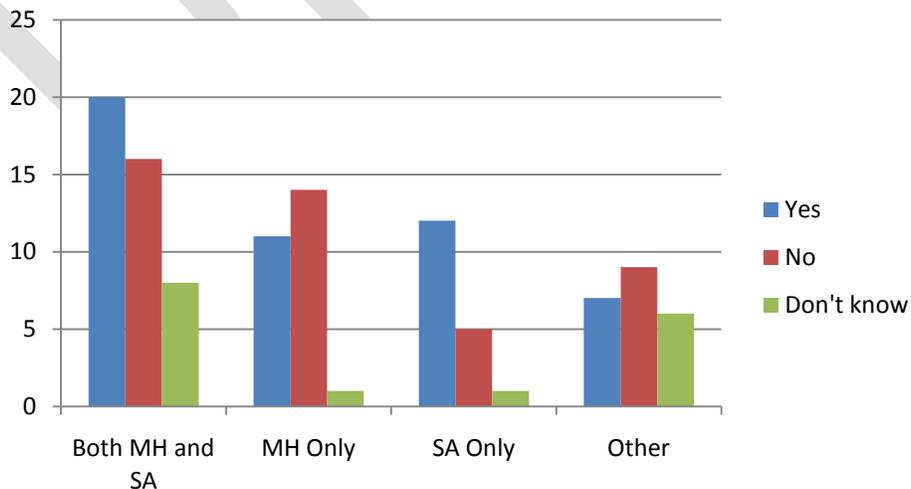
records) and, if so, what kinds of patient information were shared between care providers. Sixty-five respondents indicated that the question was relevant to them. Figure 18 is the number of “yes” answers from each BH service sector to a question about whether they shared problem list, treatment plans, medication lists and lab results between BH and medical health providers within their organizations. Generally speaking, if an organization shared one data type, it shared all the data types.

Figure 18: Data types shared between BH and Medical health providers (n=65)



However when individual data types were examined by sector (an example of which is shown in Figure 19) it was clear that not all organizations had yet implemented sharing between medical and behavioral health providers.

Figure 19: Sharing of Treatment Lists Between Providers Analyzed by Service Sector (n=65)

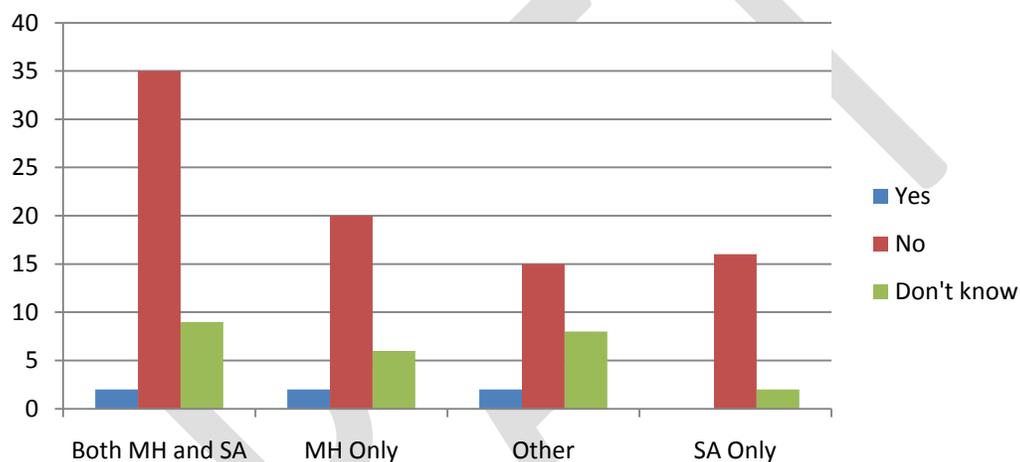


The data shown in Figure 19 is in response to whether behavioral health Treatment Plans were shared between medical and behavioral health providers. While some proportion of each sector did share this Treatment Plan information, in all cases a significant proportion still did not share or restricted access. The data for Treatment plans is representative of that seen for medical problem lists, medication lists and lab results. The survey did not ask respondents to indicate why they did not share data.

Disease Registry Participation

Respondents were asked to indicate whether they shared information with any disease registries in order to facilitate the sharing of demographic or clinical information with other medical or behavioral health providers.

Figure 20: Participation in disease registries, segmented by BH service sector (n=117)



As shown in Figure 20, very few organizations of any type indicated that they participated in a disease registry. Whether this is because they were unaware of them, lacked the technology to connect with the registries or had actively decided not to share information to protect patient information was not explored.

Awareness of Data Exchange Technology

The state of Illinois Health Information Exchange (ILHIE) recently launched ILHIE Direct, a secure email tool that allows medical and behavioral health providers to share patient information in a HIPPA compliant fashion. As part of the BHO survey, organizations were asked whether they thought they would benefit from the use of ILHIE Direct. Figure 21 shows that while almost 50% of those who answered the question (n=110) thought Direct would benefit their organization, almost 40% indicated that they didn't have enough information to answer yes or no. When asked whether they would register for Direct (Figure 22) the percentage that didn't have enough information to answer rose to 61%. 44% were likely or somewhat likely to use the Direct service (Figure 23) but 40% still felt they didn't have enough information to make a decision. Taken together, this suggests that there is a lot of potential for ILHIE Direct in the BH community, but that further outreach to explain the benefits and uses of the system is still critical to engage the BH community around this service.

Figure 21: Organizational Benefit from ILHIE Direct? (n=110)

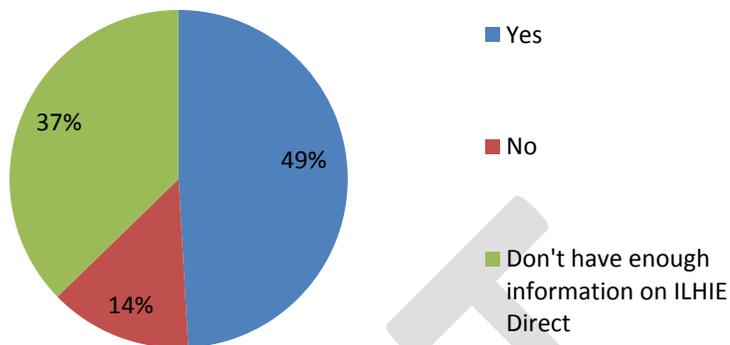


Figure 22: Will Your Organization Register for ILHIE Direct (n=110)

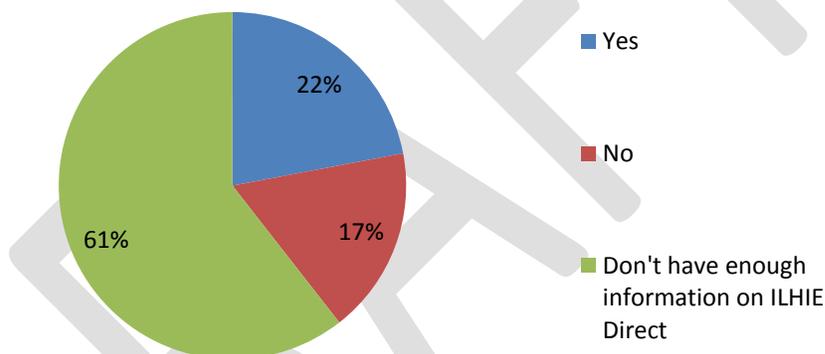
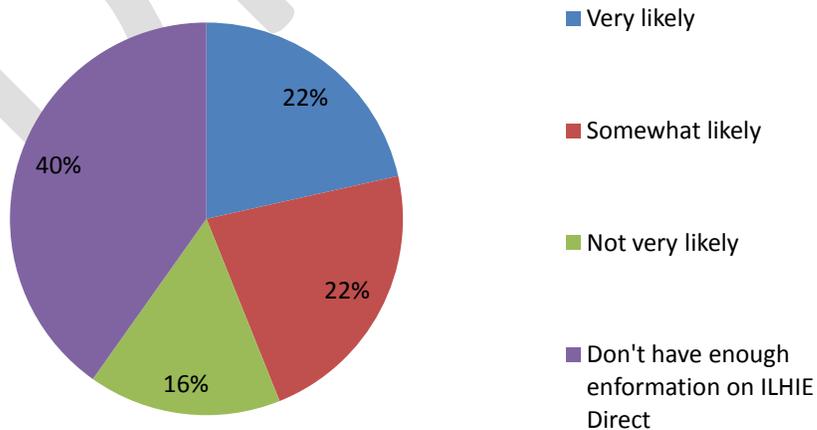


Figure 23: Will Your Organization Use ILHIE Direct? (n=110)



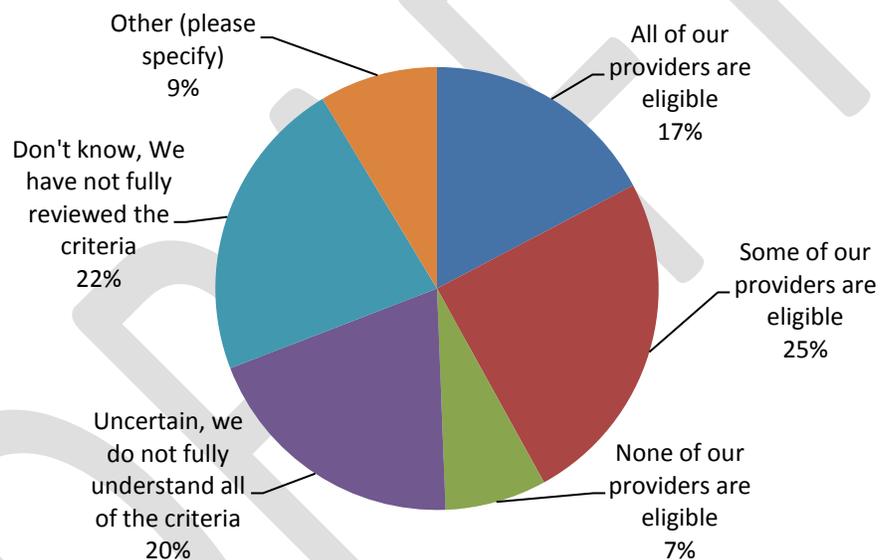
EHR Incentive Programs

The Center for Medicaid and Medicare Services (CMS) developed the EHR Incentive program to encourage health care providers to adopt and effectively use EHR technology. This program provides health care providers with up to \$65,000 per provider to adopt and achieve “Meaningful Use” of an EHR. The BHO survey queried the participating organizations on their awareness of the program and concerns about participation.

Incentive Program Participation

BH organizations were asked to indicate whether they had reviewed the participation criteria to determine whether there were “eligible professionals” from their organizations who could participate in the program. The results from this question are presented in Figure 24.

Figure 24: BH Organization Awareness of Provider Eligibility for EHR Incentive Programs (n=81)

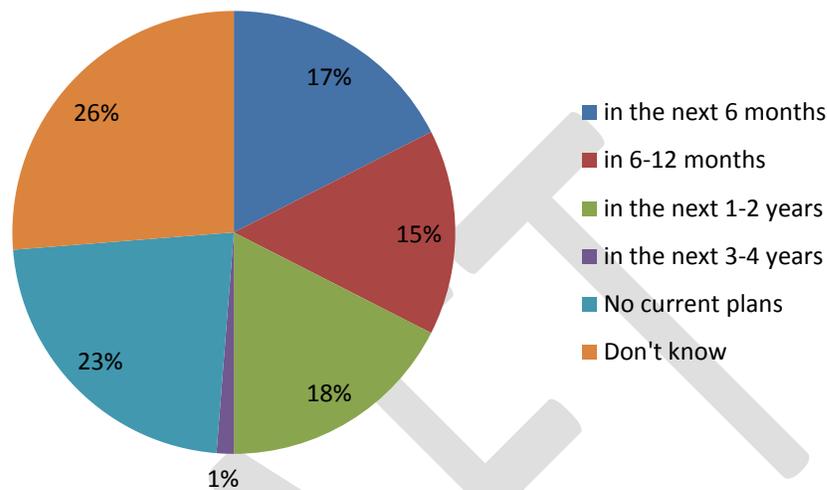


Forty-nine percent of the 81 respondents were aware of the incentive program and had enough knowledge to determine whether they had personnel who were eligible to participate. Fully 42% of organizations believed that some or all of their providers were eligible for the program, while another 42% did not know enough about the program to know. This suggests that the incentive program could be a source of funds to help BH organizations adopt EHRs, but also that many of these organizations would benefit from additional education on the incentive programs and their benefits.

Organizations were also asked what their timeline for participation in the Medicaid incentive program was likely to be. The results are shown in Figure 25. 50% intend to participate in the next 2 years, 23% have no plans to participate and 26% don't know whether they will participate. This is consistent with the level of knowledge of the program discussed previously. It also suggests that there is a group of organizations that

may need assistance determining whether they can participate so as not to lose the opportunity to benefit from the incentive funds.

Figure 25: Timeline for Incentive Program Participation (n=80)



Concerns about Meaningful Use

Survey participants were asked to indicate their readiness to comply with the 15 core measures of Meaningful Use and the 10 menu measures. They were allowed to select from 4 defined options: ready now, ready by 2012, not ready by 2012 and unsure. Seventy-six participants responded to these questions.

Readiness for the 15 Core measures is examined in Figure 26. There is significant variation in the responses for each measure, but overall, the BH organizations seemed most confident about meeting the Demographics (Core 4), Problem List (Core 5), Medication List (Core 6), Allergy List (Core 7), Smoking Status (Core 9) and PHI Protection (Core 15) measures by 2012. They anticipated the most challenges in meeting the CPOE use (Core 1), ePrescribing (Core 3), Patient eCopy (Core 12) and information exchange (Core 14) measures.

Readiness for the 10 Menu measures is examined in **Error! Reference source not found.** For the incentive program, a participant needs to meet 5 of the 10 menu measures to demonstrate MU. The data suggests much more uncertainty with meeting the menu measures, but the biggest challenges are associated with Drug Formulary use (Menu 1), including lab results as structured data (Menu 2), providing patient education resources (Menu 6) and medication reconciliation on transitions of care (Menu 7).

Figure 26: Readiness for Meaningful Use Core Measures

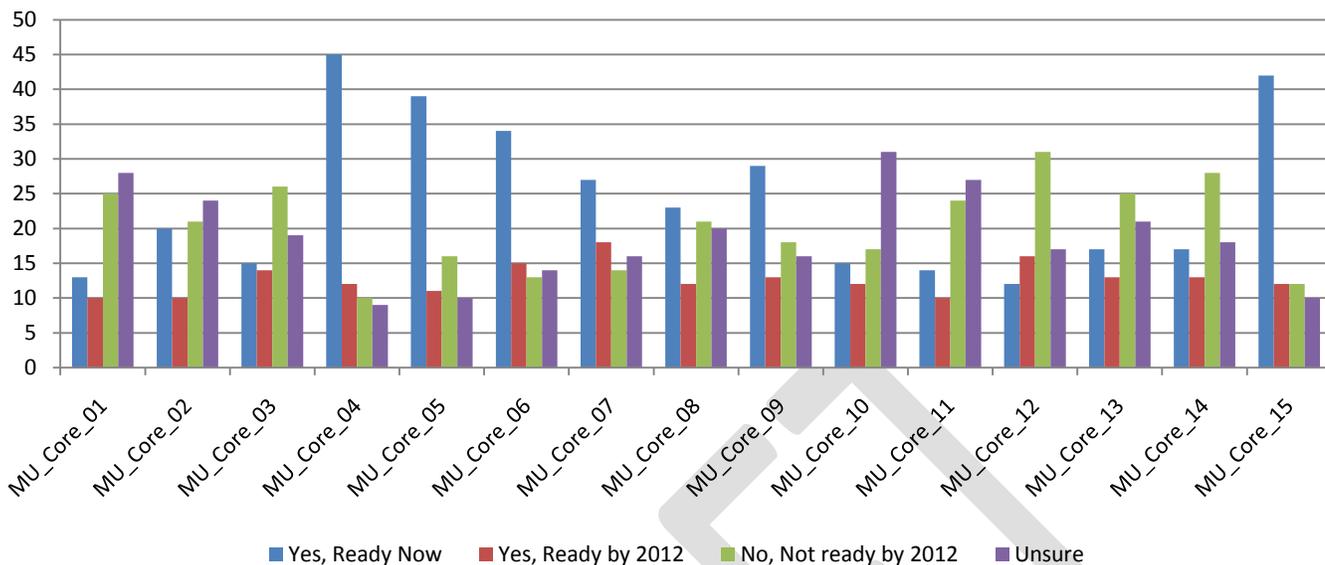
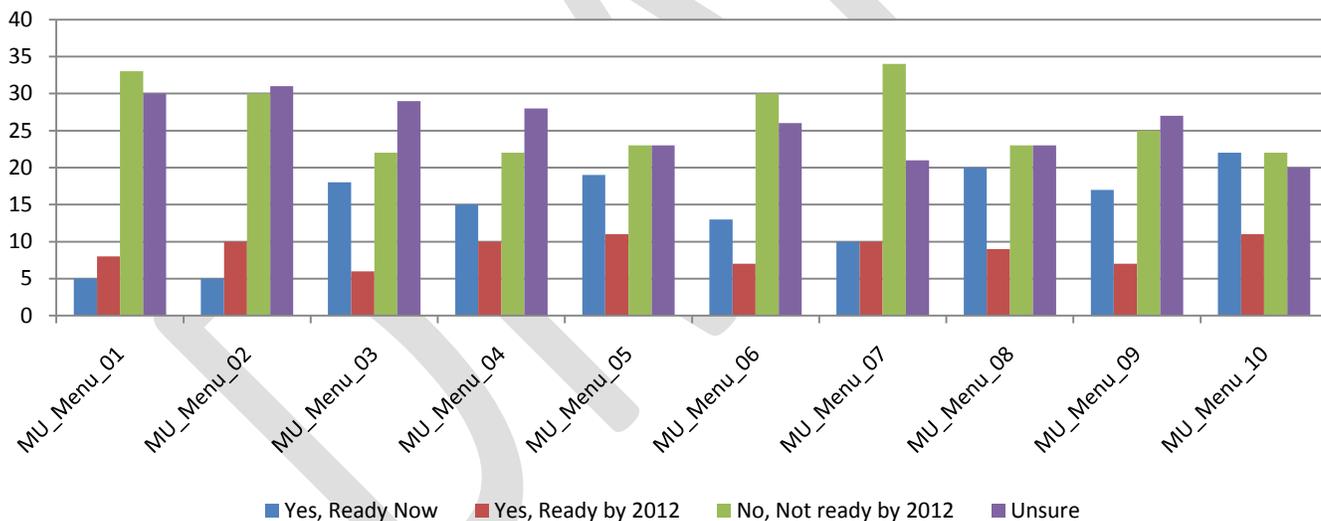


Figure 27: Readiness for Meaningful Use Menu Measures (n=76)

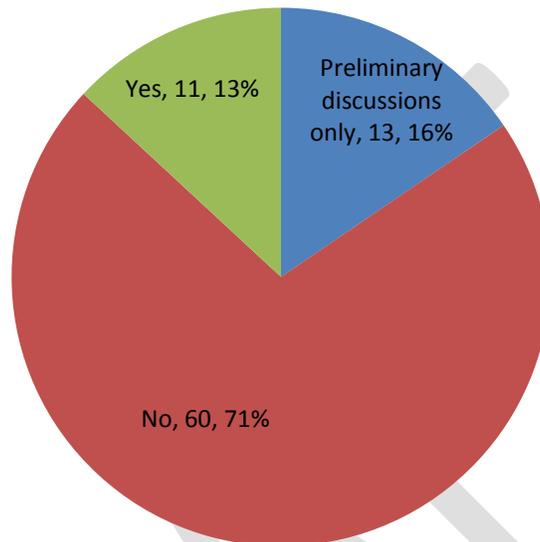


Reporting and MU Assistance

Successful achievement of meaningful use is often facilitated by access to good reporting tools that help organizations understand how providers are performing on their measures and education/support for adjusting workflows to better integrate the EHR into daily operations.

To better understand the access to good reporting tools, survey participants were asked to indicate whether they were participating or preparing to participate in a clinical data warehouse that would help them gather information on performance measures. The results are presented in Figure 28.

Figure 28: Participation of BH Organizations in Data Warehouse Projects

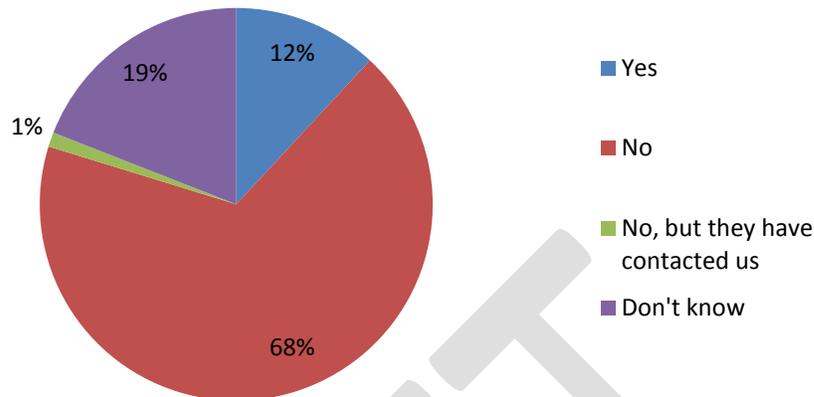


Of the 84 responses to this question, 13% were participating in a data warehouse, 16% were in preliminary discussions to participate in a data warehouse, and 71% indicated that they were not participating in a data warehouse program. This suggests that BH organizations may need additional support to help them measure their progress to Meaningful Use as well as on clinical quality measures related to behavioral health care.

To help support the achievement of Meaningful Use by primary care providers, the Office of the National Coordinator for health IT established the Regional Extension Center (REC) program to provide additional educational and technical support to primary care providers working towards Meaningful use. The RECs are meant to be a significant Meaningful Use resource for all in their assigned territory. Illinois has 2 RECs, IL HITREC, which is tasked with all of Illinois outside of the City of Chicago and CHITREC, which was created to support MU in the 606xx zip codes of Chicago. BH organizations were asked to indicate whether or not they had a relationship with one of the RECs in Illinois.

As shown in Figure 29, only 12% of the 84 organizations that responded to this question were working with their REC. Of the 14 organizations that had worked with an REC, 10 found the relationship to be at least somewhat beneficial (data not shown). This suggests that BH organizations may not be aware of all the resources available to support their progress towards Meaningful Use of an EHR, should they choose to have members of their staff participate in the EHR incentive program.

Figure 29: BH Organization Involvement with Illinois Regional Extension Centers (n=84)

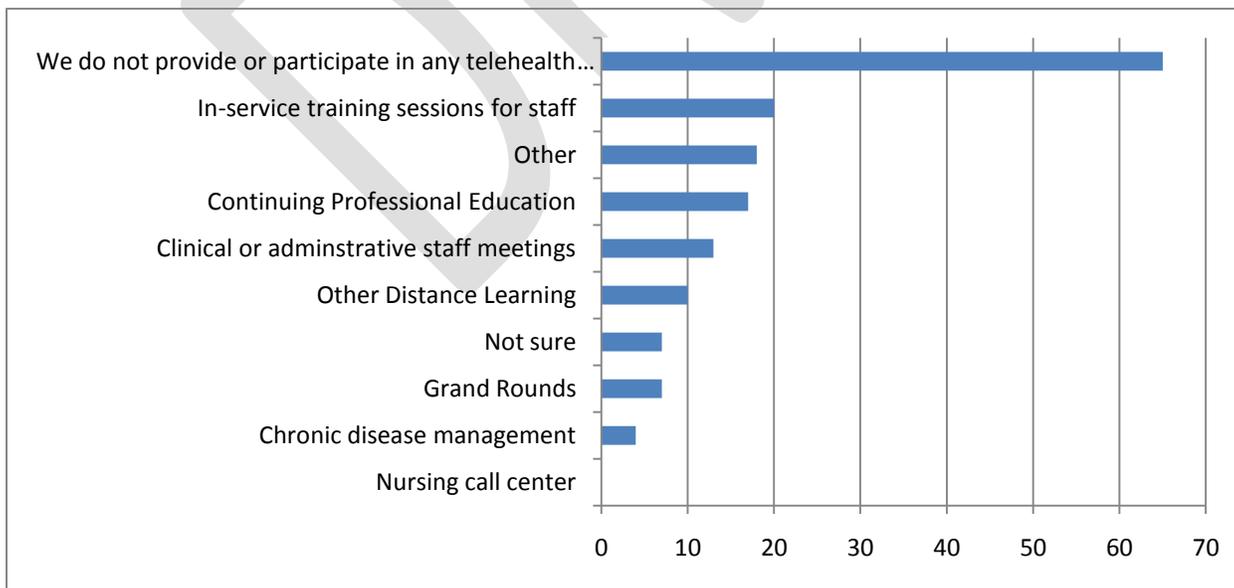


Tele-Health

Tele-health services represent a mechanism by which BH organizations can benefit from education, coordination and consulting remotely for patients and staff members. As part of the BHO survey, participants were asked to describe their level of participation and interest in these services.

Participants were first asked to indicate what tele-health services they participated in. They were able to select from one or more of the 10 pre-defined options and a write in "other" option. The results from this question are presented in Figure 30.

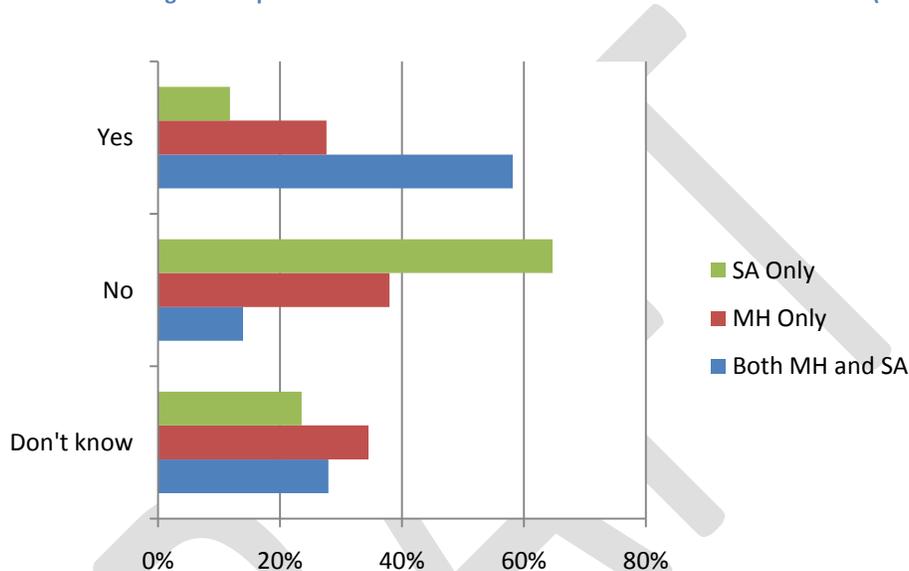
Figure 30: Participation in Tele-health Services by Illinois BH Organizations (n=XXX)



The majority of the respondents indicated that they did not provide or participate in tele-health. For those that did, staff education was one of the primary uses.

Participants were then asked if they foresaw their organization integrating tele-health or tele-medicine services into their care delivery models in the near future. The responses were roughly equally divided between yes (37%), no (37%) and unsure (26%). When the results were analyzed by BH service sector (as seen in Figure 31), there was some differentiation.

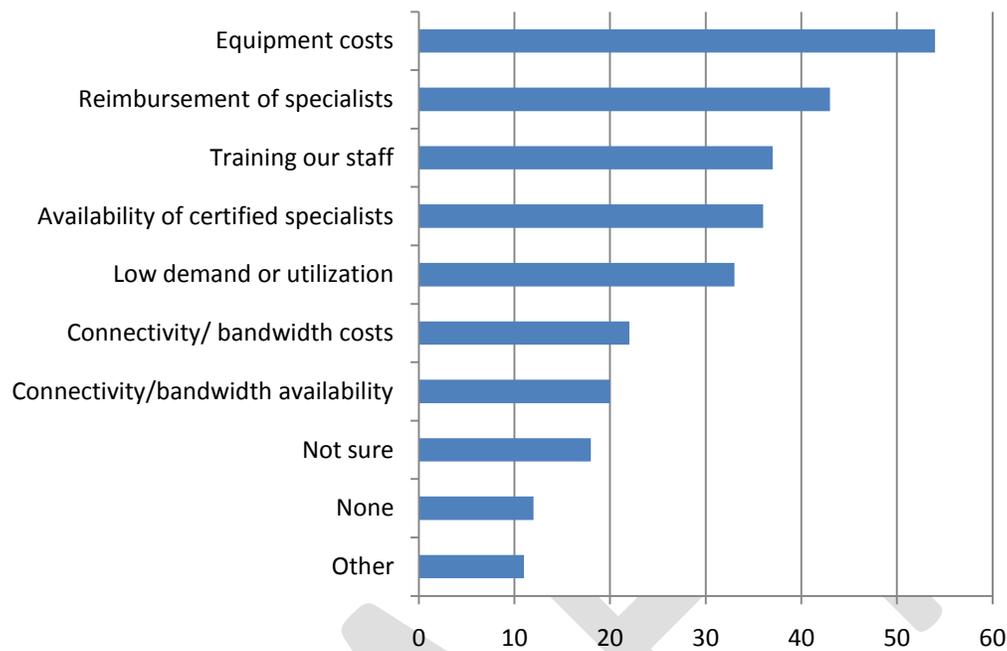
Figure 31: Percentage Participation of BH Service Sectors in Tele-Health In the Near Future (n=113)



Almost 60% of organizations that provided both MH and SA services, anticipated integrating tele-health and medicine services into their operations within the next 2 years. Conversely, just over 60% of organizations that only provide SA treatment indicated that they did not foresee integrating tele-health services. Organizations that only provided MH services had roughly equal proportions of those that did and didn't foresee using tele-health services. This result is similar to that observed for EHR adoption, where the service sector that indicated it was least likely to adopt EHR technology was the SA treatment only group.

Finally, participants were asked to indicate what barriers they saw to implementing tele-medicine and tele-health services. They were given a pre-defined list of ten choices and could select all that applied. The biggest barrier was the perceived cost of equipment to support these services, followed by the cost of reimbursing the specialists who would be accessed with the services and staff training. Figure 32 presents the complete results.

Figure 32: Primary Barriers to Tele-health/Tele-Medicine Technology Adoption in BH Organizations (n=XXX)



Survey Limitations

This survey was offered to all state funded and licensed BH providing organizations and organizations that participate in the Illinois Psychiatric Society. Respondents were invited to participate by email and the survey was administered online. Given that the study was announced and administered electronically, it could bias the dataset towards those organizations that are more effective users of electronic communications and on line tools. This may mean that the number of organizations on an EHR or planning to use an EHR may be overrepresented relative to the actual representation in the state of Illinois. Given the responses to the survey that suggested that substance abuse treatment facilities might be less geared to electronic communication, as well as the fact that they made up only a relatively small proportion of the respondents, their interests may need to be further investigated to get a more complete picture.

Finally, there are a number of organizations that participated in the surveys (such as hospital industry groups) that may have been there to better understand the BH landscape and may not be candidates for EHR adoption. These groups fall into the “other” category when the data is presented so that their information is represented but does not obscure BH service providing organizations.

Conclusions, Recommendations and Next Steps

This survey was performed to better understand where Illinois behavioral health providing organization sat on the HIT implementation spectrum. At a time when coordination of care for all patients is coming front and

center in the health care arena, it is critical that all health care providers have access to technology that allows for effective documentation of patient information and exchange of that information, when necessary to ensure the highest possible care for all people in Illinois.

This survey included organizations that provided mental health and substance abuse treatment services, either separately or in combination. It is encouraging to see that the behavioral health community is adopting electronic health records. 62% of respondents indicated that they had either fully or partially moved their records to electronic format. 40% indicated that they had either fully or partially implemented an EHR system, and another 34% plan to implement one in the next several years. Within the group that had adopted an EHR, there is a small body of organizations that have been using an EHR system for 5 or more years. These experienced vanguard organizations could be a source of knowledge, use cases and best practices for the cohort that are beginning their EHR adoption process.

While there is enthusiasm for the adoption of HIT, behavioral health organizations may lack the financial and human resource to adopt HIT systems successfully. 65% had allocated 2% or less of their yearly operating budget to HIT and while over half of the organizations indicated that they had full or part time IT support or could access it through contracting, only 16% indicated that they had a full or part time IT leadership person to direct their HIT initiatives. Nationally, medical organizations are estimated to dedicate 3.5% of their operational budget to HIT and it has also been shown that IT leadership and support of HIT adoption programs is critical for their success.

At the same time, only half of the behavioral health community was aware of the EHR Incentive program and understood it well enough to know their personnel were eligible for this program. Making sure that behavioral health organizations had access to education and support for EHR adoption and Meaningful Use achievement could open up additional funds to support EHR adoption in these organizations. The Regional Extension Center program was established to assist primary medical care providers in the adoption of EHR. It may be that RECs could be effective resources for behavioral health organizations as well.

While behavioral health organizations were interested in data exchange and some behavioral health organizations that provided both mental health and medical care services had developed mechanisms for sharing patient information between providers to coordinate care, at the time of this survey, most behavioral health organizations knew little of external secure exchange mechanisms. More efforts need to be made to ensure that these organizations better understand how to use services such as IL HIE direct and that as state-wide HIE becomes available, appropriate education and tools are available to help behavioral health organizations participate in the data exchange process to improve care coordination in Illinois.

Finally, while the overall trend for HIT adoption amongst the behavioral health community was a positive one, when the survey responses were assessed by behavioral health service sector, it was clear that those organizations that provided solely substance abuse treatment lagged those that provided mental health services or a combination of mental health and substance abuse treatment. They were more likely to rely solely on paper charts and more likely to be in the group that indicated that they were not planning to implement an EHR system. They were also less likely to have IT leadership or IT staffing of any kind and showed significantly less interest in participating in tele-health and tele-medicine services. It will be important

to develop a better understanding of these organizations and their needs to make sure that they have the tools and resources necessary to support the adoption of electronic tools that would provide for better care coordination for their patients.

ⁱ We need a reference for average HIT spending – seems to come from 2009 survey/marketing data

DRAFT