

Informational Technology and Electronic Health Records for Behavioral Healthcare Providers



Ohio
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The mind and body are one. Behavioral health¹ is essential to overall health, and behavioral healthcare providers are beginning to work more closely with all other healthcare providers. As behavioral healthcare providers fully participate in clinical information sharing with physical healthcare providers through integrated care, the resulting efficient, productive service delivery system will improve the health and wellbeing of the people both providers serve.

Because behavioral healthcare and physical healthcare have acted as two different systems, there are many things that they do differently to improve the health of their patients. One way is through the use of information technology (IT). Physical healthcare providers are increasingly replacing paper charts with electronic health records (EHR), which are a cornerstone of an efficient, integrated healthcare delivery system: A recent study of primary care practices in Massachusetts found that the use of advanced EHR systems correlated most strongly with improved outcomes.²

EHR and IT hold the promise of improved effectiveness and efficiency for behavioral healthcare providers, as well:

Information technology is a dynamic and evolving force in behavioral healthcare and human services. As funding barriers are addressed and as more providers realize the benefits of full system acquisition and implementation, the impact of information technology on the efficiency and the effectiveness of service delivery can be expected to increase significantly. —Paul M. Lefkowitz³

¹ Behavioral health includes both mental health and substance abuse disorders.

² Mark W. Friedberg, et. al., "Associations Between Structural Capabilities of Primary Care Practices and Performance on Selected Quality Measures," Commonwealth Fund, October 6, 2009

³ Paul M. Lefkowitz, Behavioral Health/Human Services Information Systems Survey, June 2009.

However, according to the Behavioral Health/Human Services Information Systems Survey, mental healthcare and human services providers lag far behind general healthcare providers in access to HIT. The survey found that providers of mental health and addiction services spend half as much as primary care providers on HIT and employ about a third as many IT professionals. Fewer than half of all behavioral healthcare and human services providers have fully implemented clinical electronic records systems. And, most of these providers expect to spend less on HIT next year because of decreasing funding.⁴

Provisions in the American Recovery and Reinvestment Act (ARRA), signed into law in February 2009, can help behavioral healthcare providers make good on the promise of EHR and IT. The ARRA created a variety of incentives "for healthcare providers to support the adoption and sustained use of health information technology (HIT)," including:

- Support for the creation of regional centers to provide technical assistance and play a primary role in disseminating best practices from the proposed federal Health Information Technology Research Center.
- Planning and implementation grants to states or state designated entities to facilitate and expand the use of HIT among organizations in that state.
- Grants to states to establish a HIT loan fund for providers to help them implement certified EHR technology.
- Grants to demonstration projects to develop curricula that incorporates EHR technology in the education of health professionals.
- Medicare incentive payments for the meaningful use of certified EHR technology.
- Medicaid incentive payments for the adoption of certified health information technology.

This paper will discuss the key concepts, federal incentives, and what is happening in Ohio around EHR and HIT.

⁴ *Ibid.*

Key Concepts and Definitions

Just as there are many software programs for managing names and addresses, there are many EHR systems. In order for EHR and the exchange of electronic health information exchange to be useful in improving health outcomes, these various EHR systems must use similar definitions and standards so that data are compatible across providers. The software, technology, and healthcare industries have been discussing these definitions and standards for the past several years and will continue to discuss them for the foreseeable future.

Electronic Patient Records

A crucial part of the HIT discussion is an agreement on what electronic patient records are and look like. Distinctions between similar terms are sometimes arbitrary and not everyone agrees on them. The National Alliance for Health Information Technology (NAHIT), under contract with the Office of the National Coordinator for Health Information Technology (ONC) and with input from a variety of stakeholders, produced a report in April 2008 providing consensus definitions of a number of HIT terms. The ONC approved several key definitions for electronic patient records, included below, which we will use throughout this paper.

Electronic Health Record (EHR)

An EHR contains health-related information on an individual that conforms to nationally recognized standards including content and interoperability. An EHR can be created, managed, amended, and consulted by authorized healthcare providers and staff across multiple organizations nationwide, with appropriate privacy safeguards. In addition to medical and clinical data, it may contain data on the patient's insurance benefits, medications, and demographics.

Basically, the EHR collects all of a patient's data from all of that patient's providers into a single record. This allows a clinician or doctor to treat the whole patient rather than a limited set of specific symptoms. The EHR gathers information over time and becomes a comprehensive, longitudinal record of the patient's health history. EHRs from multiple

patients can also be combined and can become a powerful research tool to study, for example, the relative effectiveness and costs of various treatments.

Electronic Medical Record (EMR)

An EMR contains health-related information on an individual that can only be shared within one or among a limited number of healthcare organizations. The EMR may look a lot like an EHR, but it was designed on proprietary software that does not meet nationally recognized standards. Sharing, therefore, is limited to organizations that use the same or similar software.

Personal Health Record (PHR)

A PHR is an EHR that a patient uses to manage his or her own health. Because the PHR conforms to nationally recognized interoperability standards, it combines the patient's data from all of their providers who use EHRs.

The Central Role of Interoperability

Central to making efficient health information exchange possible is the "interoperability" of various EHR systems. In other words, each system needs to be able to integrate the data of the other system accurately so that providers can share patient information regardless of specific software packages. These nationally recognized interoperability standards would allow the exchange of health information to improve the health of individuals through coordination of care among multiple providers, quality control, utilization review, and translating research into best practices.

Currently, there are few nationally recognized standards for exchanging health information reliably and securely. This restricts the ability of doctors, clinicians, payers, patients, researchers, and others to access all information necessary to serve patients and public health effectively and efficiently. Representatives from the interested industries are working on developing interoperability standards under the direction of the Office of the National Coordinator. This process is incremental and long-term, with pieces of it being phased in as agreements are reached.

Once there is a single set of standards, vendors will need to produce software that meets these national standards. As a central part of this process, the Certification Commission for Healthcare Information Technology (CCHIT) reviews HIT products to ensure that they conform to emerging national standards of functionality, security, privacy, and nationwide interoperability.

Meaningful Use

Many people involved in EHR discussions talk about “meaningful use” of records and data. This term means different things to the different stakeholders. Some emerging definitions of meaningful use are described below.

Centers for Medicare & Medicaid Services’ Definition of Meaningful Use

To spur the development of useful EHRs and effective health information exchange, the ARRA authorized the Centers for Medicare & Medicaid Services (CMS) to provide payment incentives for Medicare and Medicaid providers who engage in “meaningful use” of EHRs in serving Medicare and Medicaid patients. CMS is still working on the official definition of meaningful use. It expects to publish a draft definition for the purposes of receiving Medicare and Medicaid incentive payments by December 31, 2009. The public can then comment on the definition, and CMS will consider these comments before deciding on the final, official definition of the term.

CMS’ official definition of meaningful use will probably include that the healthcare provider exchange and use health information—including for prescriptions—at the point of care to improve healthcare. The definition will also include provider-specific requirements. For example, the EHRs used by behavioral healthcare providers would have to include certain data fields specific to behavioral healthcare. CMS will consult with healthcare providers in all disciplines to determine what fields are necessary.

CMS expects to roll out its meaningful use incentives in stages through the end of 2010. Current proposals indicate that the rule will phase in additional requirements for meeting the

definition of meaningful use over a period of several years. Some provider groups have expressed concern about the feasibility of meeting the current federal time line. For more information on CMS’ definition and implementation of meaningful use, see: http://healthit.hhs.gov/portal/server.pt?open=512&objID=1325&&PageID=16490&mode=2&in_hi_userid=11113&cached=true.

Health Information Technology Policy Council’s Definition of Meaningful Use

In consultation with a variety of groups, the Health Information Technology Policy Council made final recommendations to the ONC in August 2009 for defining meaningful use. According to this Council, for EHR to be used in a meaningful way, the EHRs must allow providers to meet the Council’s *Health Outcome Policy Priorities’ Care Goals, Objectives, and Measures for 2011, 2013, and 2015*:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and families
- Improve care coordination
- Improve population and public health
- Ensure adequate privacy and security protection for personal health information

Other Definitions of Meaningful Use

Some discussions of meaningful use revolve around what an EHR needs to include. There seems to be consensus around an EHR needing the following components in order to be used in a meaningful way:

- Clinical summaries
- Lab results
- Medication history
- Patient health record integration
- Public health reporting
- Electronic prescribing
- Patient messaging
- Recording quality metrics
- Patient access to health information

Evaluation Tools

There are a number of resources available to help end-users evaluate software and hardware products that would support the evolving national standards for EHR and HIT, including meeting criteria for

interoperability and meaningful use. These resources fall into two broad categories:

- Evaluation criteria that help providers make their own judgments about which products are best for them. Some of these are available to the general public, others require membership in the professional organization that created them.
- Evaluation tools that rate specific EHR systems in a variety of categories and that make recommendations based on the needs of the provider requesting the evaluation. These usually have a cost to them since a third party is doing the evaluation for the end-user. Others require membership in a professional organization.

Using these resources to choose an EHR system now is difficult because the national standards for interoperability and meaningful use are still under construction and will be evolving over time. Healthcare providers thinking about using EHR should keep the following things in mind when evaluating a system to ensure that the final selection is a good match:

- The vendor takes into account and is up to date on current national EHR, interoperability, and meaningful use standard discussions.
- The system includes data fields specific to the end-users discipline. A number of EHR systems currently on the market fail to adequately address the needs of behavioral healthcare providers or of federally qualified health centers.
- The healthcare provider should assess the viability of the vendor, the extent of its client base, and its ability and willingness to provide technical support and upgrades over the life of the product at a reasonable cost.
- The healthcare provider should consider the hardware, software, and network requirements and the cost of equipping his or her practice with the necessary technology.
- The healthcare provider should assess how easy the EHR system is to use and whether it will help increase the users' efficiency and fit into the practice's workflow.

Infrastructure

In addition to definitions of types of records and the meaningful use of them, the ONC has defined the network infrastructure necessary for providers to use

EHR effectively. Financing, hardware, and software issues and human and organizational capacity are all crucial to the development of these networks.

Healthcare data producers and users are beginning to develop these networks locally and regionally. One concern is that these local and regional networks might function well for their specific local and regional users. However, they may not function well with other networks that formed in other regions. If these smaller networks are to exchange data nationally, they must conform to national interoperability standards and enable the flow of information reliably, consistently, accurately, and securely across multiple systems.

Data sharing networks will need to recognize two principal components of building a network infrastructure:

- The process of sharing health-related information.
- The need for an oversight structure to facilitate this sharing and to be accountable for its performance.

These two concepts are reflected in the following definitions.

Health Information Exchange (HIE)

HIE is a process where electronic health-related information is shared among organizations in a confidential and secure way that protects patient privacy and that meets nationally recognized standards for interoperability. HIE is intended to support coordination of care, research, public health, emergency response, and quality improvement.

In the past, the term "HIE" could mean either the process of exchanging health information or an organization that engaged in that process. For clarity, the consensus definition restricts HIE to describing the process.

Health Information Organization (HIO)

An HIO oversees and governs HIE among organizations according to nationally recognized standards and is accountable for that exchange being performed. This term replaces the use of

“HIE” to refer to an organization that engages in exchanging health information.

HIOs can exist for a particular geographic region, medical discipline, or other category. The exact nature of these organizations is still being defined as is the relationship between them. Examples of HIOs include:

- Regional HIOs that would bring together healthcare stakeholders within specific geographic areas to govern health information exchange within a region and between that region and the rest of the nation. The geography could be a single state, multiple states, or perhaps portions of states.
- Pediatric HIOs that would bring together stakeholders concerned with children’s healthcare to govern HIE within that discipline and with the larger national network of all healthcare providers.

Federal Incentives for EHR and HIT

The Health Information for Economic and Clinical Health (HITECH) Act provisions in the ARRA included a substantial amount of funding to develop a national HIT infrastructure and to help providers and other organizations adopt and use HIT. These included:

- Establishment and operation of the Office of National Coordinator of Health Information Technology (ONC).
- Technical assistance to healthcare providers, including Community Mental Health Centers, for adopting, implementing, and maintaining certified electronic health record technology. A federal Health Information Technology Research Center would facilitate this, as would Regional HIOs (RHIOs), labeled HIT Regional Extension Centers in the ARRA.
- Planning and implementation grants to states and qualified state-designated entities to facilitate and expand HIE, including in medically underserved communities and by patients. These grants would also encourage clinicians to work with the RHIOs and promote the use of HIT for quality improvement.
- Grants to states to establish loan funds. The loans must be to healthcare providers to

facilitate the purchase and use of certified EHR technology, train personnel in its use, and improve secure health information exchange.

- Funding for the development of HIT infrastructure nationwide.
- Grants to states and non-profits for broadband access, training, and equipment for healthcare providers as part of a package to improve broadband access generally.
- Subsidies to certain non-hospital Medicare and Medicaid providers for the adoption and meaningful use of certified HIT, see above. These provisions exclude Community Mental Health Centers.
- Subsidies up to about \$65,000 over 5 years to high volume Medicaid providers who adopt a certified HIT system starting in 2011 and temporary payments to those using certified HIT to offset cost of supporting, maintaining, or upgrading.

Hospitals, Community Mental Health Centers, and Addiction Treatment Centers are not eligible for either of the Medicare or Medicaid subsidy programs. However, hospitals that become meaningful EHR users could receive up to 4 years of financial incentive payments under Medicare beginning in 2011, and up to 6 years of incentive payments under Medicaid beginning in October 2010.

See www.grants.gov for more information about specific funding opportunities. From the home page, click on Recovery Act Grant Opportunities for a list of opportunities from all government agencies.

What’s Happening in Ohio

A broad coalition of stakeholders has met since June 2007 to create a plan for improving the quality of health and healthcare in Ohio. This resulted in the Ohio Health Quality Improvement Summit in 2008. Following the summit, a team created a draft *Ohio Health Quality Improvement Plan* and received feedback from Summit attendees and interested stakeholders unable to attend. The team compiled the comments and released the final *Ohio Health Quality Improvement Plan* in 2009. A copy of the Plan is available at http://ohqis.pbworks.com/f/OHQIP_Final.pdf.

The Plan recommendations focused on four “core collaborative transformational strategies”:

- patient centered medical homes,
- health information technology,
- payment reform, and
- informed and activated patients and individuals.

It also included the Ohio Vision for Improving Health Care:

All Ohioans achieve and maintain optimal health and wellness through access to high quality health care, healthy food, and activities that stimulate physical, mental, and emotional well-being.

All Ohioans have the information needed to make cost effective, clinically appropriate, and culturally relevant decisions related to prevention of illness and injury and treatment or care.

In addition, the Health Information Technology section of the *Ohio Health Quality Improvement Plan* calls for Ohio to “Develop a technology infrastructure that supports the adoption of electronic medical records and supports the medical home concept through a robust health information exchange.” This has come to be called the *Ohio Workplan*.

Ohio Health Information Partnership

In September 2009, OHIP was designated by the State of Ohio as the authorized nonprofit entity to oversee the creation of a statewide health information exchange. OHIP is a newly formed nonprofit whose initial board members include BioOhio, the State of Ohio, The Ohio State Medical Association, The Osteopathic Association, and the Ohio Hospital Association. OHIP’s board will be expanded in the near future to include representation from the business community, consumers, payers, university system, behavioral health providers, and community health centers.

In October and November 2009, OHIP completed submission of the federal grant application for the ARRA State Grant to Promote Health Information Technology Planning and Implementation, as well

as an application to serve as the statewide Regional Extension Center (REC) under the ARRA Health Information Technology Extension Program.

OHIP’s mission is to advance the adoption, implementation, and meaningful use of health IT among health care providers and facilitate and develop an electronic HIE in order to improve the safety, quality, accessibility, availability, and efficiency of health care for the citizens of Ohio.

OHIP will work with stakeholders through the Ohio Health Care Coverage and Quality Council (OHCCQC) <http://www.healthcarereform.ohio.gov/hccqc.aspx> to ensure the broader health care objectives for the State are met. These goals parallel national goals being developed by the U.S. Department of Health and Human Services.

The *Ohio Health Quality Improvement Plan* envisions several levels of users for the data network:

- Providers, who access data for the primary purpose of patient care. They would have view-only access to data on the network provided by others.
- Data partners, whose primary role revolves around the management of data.
- Network members, who have data available for access by other network members.
- Members such as research organizations or health-related government agencies, who are authorized to access or extract large quantities of data.
- Patients, who will only be able to access their own data, possibly through an electronic PHR. Patients would be able to monitor who has accessed their data.

Ohio’s Center of Excellence envisioned in the *Ohio Health Quality Improvement Plan* would provide a variety of services to healthcare providers to help them get maximum benefit from EHRs and HIE, including:

- Support for integration of EHRs and HIE into their practices.
- Toolkits and information on best practices in EHRs and HIE.

Improving the Implementation of Electronic Medical Records Adoption in Ohio: Challenges and Opportunities

The success of a statewide health information exchange depends on a large number of providers using EHRs. Small practices and nonprofit clinics may find the cost of adopting suitable systems beyond their ability to pay for, implement, or manage. The Ohio Health Information Partnership is considering the following strategies:

- Identifying vendors who will offer discounted, certified EHR systems, without representing them as either preferred or required vendors,
- Raising provider awareness of both HIE networks or health systems that offer affordable certified EHR solutions, given that there are currently significant discounts available through Stark exemptions.

One model for assisting small providers develop their HIT capabilities exists in the Ohio State Medical Association (OSMA) Standards of Excellence Program. In 2008, the OSMA launched a program that contracts with EHR vendors that provide OSMA members with EHR systems that meet the terms and conditions specified by the OSMA. This ensures that products purchased meet government EHR standards. The vendors also agree to provide upgrades at no additional cost as the government issues new standards. This contract means that small practices without their own IT expertise can be reasonably assured of getting usable products that won't become obsolete over the duration of the contract between the vendor and the purchaser.

Call to Action

As the federal government and states move toward incentivizing broader implementation of electronic health records (EHR) and more capacity for meaningful health information exchange (HIE), behavioral health care providers will face challenges and opportunities. For too long, behavioral health in Ohio has focused on unique and separate clinical documentation and data collection rules and standards. Work in Ohio by the Health Care Coverage and Quality Council (HCCQC) toward delivery system redesign (medical homes) and payment system reform provide opportunities for

behavioral health providers to be an integral part of more comprehensive and integrated approaches to health care delivery.

Ohio's developing approach to patient-centered medical homes has a number of important characteristics: team-based; whole person orientation; care coordination and integration; quality and safety; and enhanced access. All of these require interoperable information technology systems that facilitate the confidential and timely exchange and access to health care information.

So what does this mean for behavioral health care providers in a heavily regulated and resource-scarce environment?

- Develop EHR capacity that will comply with interoperability and meaningful use standards
 - While behavioral health provider organizations currently aren't eligible for meaningful use incentive funding, meeting meaningful use standards will be critical for health care integration and various collaborative opportunities.
 - Seek funding and technical assistance through OHIP's development of Regional Extension Centers (REC), which must include special need/underserved populations as a priority under federal grant requirements, and state-subsidized, zero-interest five year loans for IT development.
 - Ensure that behavioral health IT vendors are nationally certified and can meet meaningful use requirements for EHRs and health information exchange.
 - Consider partnerships or consortiums that provide a number of advantages: quality of care benefits (best IT practice implementation rather than just automating current practices); clinical practice benefits (more sophisticated system with better resourced consultation/implementation consistent with meaningful use); and financial benefits (standardized, consistent updates, reduces individual organizational development/implementation/maintenance costs).
 - Based on desired functionality and what will work best, consider on-site installation/maintenance/training versus Internet-based application. Many consider software delivered over the Internet the wave of the future.

- Reach out to health entities outside of behavioral health for integration/development opportunities and relationship building
 - Talk with primary care/pediatric practices, hospitals, children’s hospitals and Federally Qualified Health Centers (FQHCs).
 - Meet with existing health information exchanges (RHIOs and other health information organizations) to explore inclusion as part of health integration opportunities.
 - Evaluate existing IT/EHR standardized packages and vendors used by primary care, hospitals, FQHCs and others that may have behavioral health functionality.
 - A key in these relationship building efforts will be the ability to articulate the importance of behavioral health services in contributing to the performance of primary care practices, controlling health care costs, and reducing emergency room use, particularly for individuals with chronic and multiple disorders.
- Advocate and support changes that will improve health care integration and that make adoption of EHRs and HIE more efficient and standardized
 - Alignment of federal/state requirements for documentation and data collection/reporting.
 - Simplify and align regulatory requirements that affect addiction and mental health treatment.
 - Change or eliminate unique behavioral health documentation requirements, data collection and other regulations/requirements that create barriers to better integration with health care.
 - Add behavioral health provider organizations to the organizations that are able to receive Medicare and Medicaid incentive funds for meeting EHR meaningful use standards.

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