HIT Adoption and Readiness for Meaningful Use in Community Behavioral Health

Report on the 2012 National Council Survey

JUNE 2012
About the National Council

The National Council for Community Behavioral Healthcare (National Council) is the unifying voice of America’s behavioral health organizations. Together with our 2,000 member organizations, we serve our nation’s most vulnerable citizens — more than 8 million adults and children with mental illnesses and addiction disorders. We are committed to providing comprehensive, high-quality care that affords every opportunity for recovery and inclusion in all aspects of community life.

The National Council advocates for policies that ensure that people who are ill can access comprehensive healthcare services. We also offer state-of-the-science education and practice improvement resources so that services are efficient and effective.

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Introduction

A new survey on the use of health information technology (HIT) validates the commitment of behavioral health organizations to improve care through the use of HIT but reveals the severe limitations on adoption and implementation progress.

What’s at stake is not the health of these organizations but the health of the millions of Americans they serve. People with mental illnesses and substance use disorders have historically been excluded from the mainstream and now they are excluded from the supports for HIT adoption offered to the rest of the safety net.

The consequences of this neglect are found in the HIT Adoption and Meaningful Use Readiness in Community Behavioral Health survey report. Conducted by the National Council for Community Behavioral Healthcare and completed by more than 500 community mental health and addictions treatment organizations, this is the first survey and analysis to focus exclusively on the behavioral health sector and its preparedness for the Meaningful Use (MU) of electronic health records (EHRs).

The National Council survey found that only 2% of community behavioral health organizations are able to meet MU requirements — compare this to the 27% of Federally Qualified Health Centers and 20% of hospitals that already meet some level of MU requirements. The most significant barrier for the behavioral health sector is cost — upfront financial costs and the costs of ongoing maintenance.

This finding is not unexpected given that behavioral health organizations are not on a level playing field with the rest of healthcare. While the American Recovery and Reinvestment Act of 2009 provided more than $19 billion for incentive payments to support the adoption and MU of HIT, behavioral health organizations were not eligible to receive facility payments.

Unable to receive federal facility incentive payments, behavioral health organizations are hampered in their efforts to join the rest of healthcare in achieving the Triple Aim of improving the patient experience of care, improving the health of the populations, and reducing the per capita cost of healthcare.

The survey raises a red flag on the widening digital divide between behavioral health and the rest of healthcare. Congress can stop this growing divide by passing the Behavioral Health Information Technology Act (S. 539), which provides behavioral health organizations with the same financial incentives as their medical counterparts.

Behavioral health organizations, serving more than eight million adults, children, and families with mental illnesses and addiction disorders, are ready and eager to adopt HIT to meet the goals of better healthcare, better health, and lower costs. But reaching these goals may prove impossible unless behavioral health achieves "parity" within healthcare and receives resources for the adoption of HIT.

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President & CEO

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Vice President, HIT & Strategic Development
Executive Summary

Background

The 2012 Survey of Behavioral Health Organizations’ Adoption of EHRs and Readiness for Meaningful Use was conducted by the National Council for Community Behavioral Healthcare (National Council) whose almost 2,000 member organizations serve some of our nation’s most vulnerable citizens — more than 8 million adults, children, and families with mental illnesses and addiction disorders.

The survey, completed by more than 500 behavioral health organizations, was designed to determine the status of the mental health and addictions safety net in implementing electronic health records (EHRs) and meeting Meaningful Use (MU) standards.

The survey, the first to focus specifically on behavioral health, provides a baseline from which to monitor adoption and readiness for MU.

Key Findings

Survey findings reflect both the commitment and struggles of behavioral health organizations to adopt HIT.

Behavioral health organizations are eager to move forward on implementing EHRs. Reasons for implementation include:

- Facilitate communication with other healthcare organizations to improve care coordination (36%)
- Improve quality care and streamline operations (33%)
- Position organization for growth and expansion in emerging healthcare delivery systems (32%)

While 21% of respondents indicate they use EHRs and are completely electronic at their sites, only 11% of these organizations — or 2% of all respondents — said they could meet MU requirements by the end of 2011. A further 5% of all respondents will be ready to meet MU requirements by the end of 2012.

When asked about barriers to implementation, 30% of respondents identify “upfront financial costs” as the leading roadblock, followed by 12% who identify “ongoing maintenance costs.” Workforce issues are also significant barriers:

- Lack of dedicated staff to implement technology (9%)
- Lack of project management staff (8%)
- Lack of skills to properly select technology (8%)
- Lack of dedicated staff to maintain the systems (7%)
Only 29% of respondents indicate that they have a full time Chief Information Officer or an Information Technology Director. However, based on job titles of survey respondents, behavioral health organizations perceive HIT as important to their future and to the improved care of their clients. Almost 70% of respondents are CEOs, COOs, CFOs or VPs.

Although behavioral health organizations are not eligible for MU incentive facility payments, certain providers like psychiatrists working in the field are eligible. However, behavioral health organizations need to be educated about which practitioners may be eligible for incentives. The survey finds that 10% of respondents are uncertain about which of their staff is eligible for MU incentives and do not fully understand eligibility criteria, while 18% do not know who is eligible and have not reviewed the criteria.

National Council Recommendations

Based on the status of the mental health and addictions safety net in implementing electronic health records (EHRs) and meeting meaningful use (MU) standards, the National Council recommends that:

- Congress pass the Behavioral Health Information Technology Act (S. 539), which provides behavioral health organizations with the same financial incentives as their medical counterparts.

- The Office of the National Coordinator
  - Provide targeted funding to behavioral health organizations in Beacon Community Grant programs where the behavioral health organization is the lead.
  - Ensure that all State Health Information Exchanges include behavioral health organizations.
  - Incentivize Regional Extension Centers to support behavioral health organizations.
  - Support a program specifically targeted to use products developed under the Curriculum Development Centers Program and expand the Community College Curriculum and the Health Information Technology Competency Examination Programs implemented by ONC targeted specifically to behavioral health organizations.

- The U.S. Department of Health and Human Services provide the infrastructure and resources for groups of behavioral health organizations to collaborate to improve access to care; exchange information; establish collaborative mechanisms to meet administrative, IT, and clinical quality objectives; achieve cost efficiencies; and negotiate with public and private payers — similar to the Health Center Controlled Networks that have assisted health centers in EHR adoption.

- EHR Vendors provide lower cost entry-level systems that focus on care coordination and health information exchange with the data being portable to any EHR in the future.

Survey Design

The survey was distributed to approximately 2,000 National Council members via an electronic survey tool and completed by 505 respondents. Margin of error is calculated at plus or minus 4% with a significance level of 0.05.
Survey Design and Response

The National Council for Community Behavioral Healthcare (National Council), a not-for-profit association representing nearly 2,000 community-based mental health and addiction treatment organizations across the nation, fosters clinical and operational innovation and promotes policies to ensure that the more than 8 million low-income children, adults, and families our members serve have access to high-quality services. These organizations employ 500,000 people and provide a range of services and recovery supports for individuals with multiple chronic conditions.

To date there has not been a comprehensive review of health information technology (HIT) issues in behavioral health organizations. The National Council’s HIT Adoption and Readiness for Meaningful Use in Community Behavioral Health 2012 Survey is a first-of-its kind initiative.

The survey was distributed to approximately 2,000 National Council members via an electronic survey tool and completed by 505 respondents. Margin of error is calculated at plus or minus 4% with a significance level of 0.05.

With a response rate exceeding 28%, the survey provides a comprehensive review of HIT adoption and barriers in behavioral health.

Survey responses show that despite being excluded from Meaningful Use (MU) facility payments, community behavioral health organizations are striving to implement electronic health records (EHRs) and make themselves meaningful users of technology to improve care quality and coordinate care with physical health providers. The struggle is significant.
Chapter 1: Respondent Profiles and Resources

Survey respondents provide a wide array of mental health and substance use treatment services and are the prefect cross-section of behavioral health organizations in the nation.

**Who Completed the Survey**

Nearly 90% of surveys were completed by C-suite executives and administrators — the key decision-makers on HIT adoption and implementation. See Chart 1.

**Chart 1**

![Pie chart showing who completed the survey: 68% Other Admin, 21% CEO, COO, CFO, VP, 3% Administrator/Director Level, 8% IT]
Responses by State

Chart 2 identifies the responses by state for all National Council member organizations providing services. This response rate provides a good cross section of our membership and is representative of behavioral health organizations nationally.

Chart 2

Multiple Service Locations

Organizations that responded to the survey indicated that they provide services at numerous locations. More than 54% of the respondents provide services at six or more sites and 14% provide services at 20+ sites. See Chart 3.

HIT is critical to effectively coordinate care and track services across multiple locations.

Chart 3
Full Time Employees

Nearly 40% of organizations that responded to the survey have fewer than 100 full time employees. See Chart 4.

Chart 4

<table>
<thead>
<tr>
<th>Full Time Employees</th>
<th>N=504</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-25</td>
<td>10%</td>
</tr>
<tr>
<td>26-100</td>
<td>14%</td>
</tr>
<tr>
<td>101-250</td>
<td>20%</td>
</tr>
<tr>
<td>251-500</td>
<td>29%</td>
</tr>
<tr>
<td>&lt; 500</td>
<td>27%</td>
</tr>
</tbody>
</table>

Corporate Status

An overwhelming majority of the survey respondents (95%) are nonprofit organizations. See Chart 5.

Chart 5

<table>
<thead>
<tr>
<th>Corporate Status</th>
<th>N = 493</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Profit</td>
<td>5%</td>
</tr>
<tr>
<td>Non Profit</td>
<td>95%</td>
</tr>
</tbody>
</table>
Range of Services Provided

More than 70% of respondents provide more than one type of treatment service. Nearly 80% of respondents provide outpatient mental health services, while more than 50% also provide outpatient substance use services. See Charts 6 and 7.

Chart 6

![Chart 6](image)

Chart 7

![Chart 7](image)
Primary Care Services

Primary care services are provided by or 26% of respondents. Of those organizations providing primary care, 34% are using all electronic charts, 40% are using a combination of paper and electronic charts, and 26% are using paper charts alone. See Chart 8.

Chart 8

<table>
<thead>
<tr>
<th>Organizations Providing Behavioral Health and Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 109</td>
</tr>
<tr>
<td>26% Combination of paper and electronic charts</td>
</tr>
<tr>
<td>40% Electronic charts</td>
</tr>
<tr>
<td>34% Paper charts</td>
</tr>
</tbody>
</table>

Rural vs. Urban Sites

The number of organizations identifying themselves as being in urban, rural, or both urban and rural area was spread evenly across respondents. See Chart 9.

Chart 9

<table>
<thead>
<tr>
<th>Rural vs. Urban Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 429</td>
</tr>
<tr>
<td>33% Combination of paper and electronic charts</td>
</tr>
<tr>
<td>35% Electronic charts</td>
</tr>
<tr>
<td>32% Paper charts</td>
</tr>
</tbody>
</table>
Percentage of Operating Budget Dedicated to HIT

Percentage of operating budget dedicated to HIT may be a precursor to effective EHR adoption and readiness for MU. Nearly 70% of survey respondents dedicate 3% or less of their total operating budgets to HIT. See Chart 10.

Health Center Controlled Networks, which provide HIT support to Federally Qualified Health Centers, recommend that safety net organizations should target at least 7–10% of their total operating budget to HIT. A 2009 IT Key Metrics Report by Gartner indicates that for organizations under $50 million in total operating budget, the average IT budget is 5.51%.

Chart 10
Onsite Information Technology Staff

An adequate and trained workforce is essential for HIT implementation. Only 29% of survey respondents have an Information Technology (IT) Director or Chief Information Officer (CIO). Nearly 10% of the organizations do not have an IT Director or CIO, while 18% indicate that although they do not have IT staff, they do have a contract for these services. See Chart 11.

Implementation of an EHR may require more operational level staff. However, as more EHR vendors provide “cloud based” solutions and healthcare providers become accustomed to Software as a Service models, the need for an onsite IT Director or CIO becomes less imperative.

Chart 11
Chapter 2: Use of Electronic Health Records

Having an EHR at only one location or using it at only a few of an organization’s multiple sites does not equate to Meaningful Use of technology. While approximately 65% of all respondents identified that they use an electronic health record (EHR), only 21% indicated that they use an EHR at all their sites and that they are all-electronic at all sites. However, only 11% of these organizations can meet MU. See Chart 12.

A 2009 study co-sponsored by the Software and Technology Vendors Association, National Council for Community Behavioral Healthcare, Mental Health Corporations of America, and National Association of Psychiatric Health Systems indicated HIT adoption at a similar rate as this survey. Apparently, there has not been much progress in using EHR systems in a meaningful way over the last few years.

Chart 12

![Use of Electronic Health Record](image)
Use of Specific Electronic Health Record Products

Survey responses indicate that there is wide variation in the products and vendors used for EHRs, with a few leading the way. See Chart 13.

Chart 13

![Chart 13: Use of Specific Electronic Health Record Products](chart13)

**EHR Implementation Timeline**

Of the 199 respondents that shared their estimated timeline to adopt an EHR, 93% indicate that they will implement an EHR in the next two years or less. See Chart 14.

Chart 14

![Chart 14: EHR Implementation Timeline](chart14)
Reasons for Implementing Electronic Health Records

Behavioral health organizations recognize the importance of implementing EHRs. They know they must have the ability to communicate with other healthcare providers to coordinate care, improve organizational operations, and maintain a competitive advantage. They are also looking to position their organizations for growth and expansion, improve billing and collections, and capture data to improve reporting capabilities. See Chart 15.

Chart 15
Barriers to HIT implementation in behavioral health appear to be the same as in the rest of healthcare. Upfront financial costs were identified by 30% of survey respondents as the number one barrier while ongoing maintenance costs were identified by 12% of the respondents as the number one barrier. Other barriers indicated by respondents are lost revenue during implementation, lack of dedicated staff during implementation and to maintain the systems, and lack of skills to implement a system. Provider resistance was also identified as a barrier. See Chart 16.

Targeted HIT training for the behavioral health workforce, availability of knowledgeable consultants, and facilitating collaborations with other healthcare organizations will help to overcome these barriers.

Chart 16

<table>
<thead>
<tr>
<th>Barriers to EHR Implementation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upfront Financial Costs</td>
<td>30%</td>
</tr>
<tr>
<td>Lost revenue during</td>
<td>12%</td>
</tr>
<tr>
<td>Lack of dedicated staff to</td>
<td>9%</td>
</tr>
<tr>
<td>Lack of Project Management</td>
<td>9%</td>
</tr>
<tr>
<td>Lack of skills to properly</td>
<td>8%</td>
</tr>
<tr>
<td>Provider Resistance</td>
<td>8%</td>
</tr>
<tr>
<td>Lack of dedicated staff to</td>
<td>7%</td>
</tr>
<tr>
<td>Privacy Concerns</td>
<td>7%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>
Use of Disease Registries

Disease registries are an important HIT component and provide the capability to track consumers over time, follow up, share information with other healthcare providers, and enhance clinical decision support. However, survey respondents for the most part do not utilize disease registries. Only 8% identified that they do utilize a disease registry. See Chart 17.

Disease registries are used extensively in the FQHC arena to track patients and monitor specific diseases — behavioral health organizations serving similar populations with multiple chronic diseases should also have access to and utilize these systems.

Chart 17
Chapter 3: Meaningful Use Readiness

The National Council survey found that only 2% of community behavioral health organizations are able to meet MU requirements — compare this to the 27% of Federally Qualified Health Centers and 20% of hospitals that already meet some level of MU requirements. See Chart 18.

This finding is not unexpected given that behavioral health organizations are not on a level playing field with the rest of healthcare. While the American Recovery and Reinvestment Act of 2009 provided more than $19 billion for incentive payments to support the adoption and MU of HIT, behavioral health organizations were not eligible to receive facility payments.

Chart 18

Ability to Meet Meaningful Use Now

- Hospitals: 20%
- FQHCs: 11%
- Behavioral Health Organizations: 2%

Hospital data from AHA Letter to CMS on MU Stage 2 NPRM
FQHC data from Geiger Gibson/RCHN Foundation, George Washington University, Policy Research Brief # 27
Knowledge of Meaningful Use Eligibility

Although behavioral health organizations were not deemed eligible for Meaningful Use Incentive facility payments, certain providers working in behavioral health — psychiatrists, other physicians, and nurse practitioners — are eligible for the Medicaid Incentive Program if they meet the 30% Medicaid criteria.

There seems to be a great deal of education still required in the behavioral health sector as many organizations are not even aware if their providers are eligible for Meaningful Use Incentives. A recent report (http://www.cms.gov/EHRIncentivePrograms/Downloads/EP-PUE.zip) from the Centers for Medicare and Medicaid Services identified that only 0.63% of providers receiving Meaningful Use Medicare incentive payments were psychiatrists.

Eighteen percent do not know if their providers meet the criteria as they have not carefully reviewed it to make a determination and 10% of the respondents do not fully understand the criteria. See Chart 19.

Chart 19

Knowledge of Meaningful Use Eligibility

N = 406

- 37% All of our providers are eligible
- 27% Don’t know. We have not fully reviewed the criteria.
- 10% None of our providers are eligible
- 8% Some of our providers are eligible
- 18% Uncertain, we do not fully understand all of the criteria
MEANINGFUL USE CORE MEASURES

The survey segmented out each of the Stage 1 MU criteria to obtain a better understanding of behavioral health organizations’ readiness to meet these criteria and be eligible for incentive payments. Respondents were asked to assess their readiness to meet MU Stage 1 criteria as Ready Now, Ready by 2012, Not Ready by 2012, or Unsure. They survey examined readiness for the 15 MU Core Measures and the MU Menu Set.

Core 1: Computerized Provider Order Entry

Of the 353 organizations that answered this question only 22% identified that they can meet MU criteria for computerized provider order entry now. Twenty five percent identified they will be able to meet the criteria in 2012. Fifty-two percent however, identified that they would not meet the criteria by 2012 or were not sure. See Chart 20.

Chart 20

Core 1. Computerized Provider Order Entry
N = 353

- Yes, Ready Now: 30%
- Yes, Ready By 2012: 22%
- No, Not Ready By 2012: 25%
- Unsure: 22%
Core 2: Drug-to-Drug Interaction Checks

Fifty-five percent of the respondents identified that they will be able to perform drug-drug interaction checks by 2012 and 45% indicated that they could not meet this criteria in 2012 or were not sure. See Chart 21.

Chart 21

<table>
<thead>
<tr>
<th>Core 2. Implements Drug-to-Drug and Drug Allergy Interaction Checks</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 355</td>
</tr>
</tbody>
</table>

The 23% of respondents who indicated they will not be ready to meet eRx criteria will likely require additional training and/or support to be able to generate permissible prescriptions in a manner that meets MU criteria.

Core 3: Electronic Prescriptions (eRx)

Almost 64% of the respondents identified that they would be able to generate and transmit permissible prescriptions electronically per MU criteria now or by 2012, with 35% being able to meet it now and another 29% being able to meet it in 2012. See Chart 22.

Chart 22

<table>
<thead>
<tr>
<th>Core 3. Generates and Transmits Permissible Prescriptions Electronically (eRx)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 354</td>
</tr>
</tbody>
</table>

The 23% of respondents who indicated they will not be ready to meet eRx criteria will likely require additional training and/or support to be able to generate permissible prescriptions in a manner that meets MU criteria.
Core 4: Record Patient Demographics

MU criteria require that eligible providers record patient demographics in a structured format. The majority of survey respondents, almost 65%, identified that they would meet this criteria by 2012, with 35% able to meet the criteria now and another 29% being able to meet it in 2012. See Chart 23.

Chart 23

Core 4. Records Patient Demographics
N = 360

- 65% Yes, Ready Now
- 19% Yes, Ready By 2012
- 8% No, Not Ready By 2012
- 8% Unsure

Core 5: Problem List of Current and Active Diagnoses

Eighty percent of the respondents will be able to maintain an up-to-date problem list of current and active diagnoses by 2012. See Chart 24.

Chart 24

Core 5. Maintains an Up-to-date Problem List of Current and Active Diagnoses
N = 359

- 58% Yes, Ready Now
- 22% Yes, Ready By 2012
- 11% No, Not Ready By 2012
- 9% Unsure
Core 6: Active Medication List

Eighty percent of the respondents identified that they are currently able to or will be able to maintain an active medication list by 2012. See Chart 25.

![Chart 25](chart25.png)

Core 7: Active Medication Allergy List

Eighty percent of the respondents identified that they are able to maintain an active medication allergy list or will be able to do so by the end of 2012. See Chart 26.

![Chart 26](chart26.png)
Core 8: Charts Vital Signs

Only 63% of the respondents identified that they can record and track vital signs, with 34% able to do this now and 29% able to do this by 2012. Thirty-seven percent indicated they will not be able to record or chart vital signs by 2012 or are unsure. See Chart 27.

Behavioral health organizations treat clients with multiple comorbid medical conditions. Recording and tracking vital signs are basic functions for monitoring, tracking, and intervening proactively in their care.

We found that if a behavioral health organization is providing primary care services, it is more likely to be able to record and chart changes in vital signs, with 76% of the 114 that provide primary care being able to do so by 2012 and only 58% of those not providing primary care being able to do so by 2012. See Chart 28.

Chart 27

![Chart 27](image)

Core 8. Records and Charts Changes in Vital Signs
N = 359

- Yes, Ready Now: 34%
- Yes, Ready By 2012: 21%
- No, Not Ready By 2012: 29%
- Unsure: 16%

Chart 28

![Chart 28](image)

Records and Charts Vital Signs (by 2012): With Primary Care

- Provide Primary Care Services N = 114
- Do Not Provide Primary Care Services N = 261

- 76%
- 58%
Core 9: Records Smoking Status

Sixty-six percent of respondents identified that they are able to record smoking status now or by 2012. There is concern about the 34% that will not be ready by 2012 or are unsure. See Chart 29.

Chart 29

<table>
<thead>
<tr>
<th>Core 9. Records Smoking Status for Patients 13 Years or Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 358</td>
</tr>
<tr>
<td>36% Yes, Ready Now</td>
</tr>
<tr>
<td>18% Yes, Ready By 2012</td>
</tr>
<tr>
<td>16% No, Not Ready By 2012</td>
</tr>
<tr>
<td>30% Unsure</td>
</tr>
</tbody>
</table>

Core 10: Clinical Decision Support

Only 17% of the respondents identified that they are able to implement one clinical decision support rule now and 25% identified they will be able to do this by 2012. Fifty-eight percent indicated they will not be ready in 2012 or are unsure. This is a serious shortcoming in behavioral health practice as clinical decision support is integral to improving outcomes. See Chart 30.

Chart 30

<table>
<thead>
<tr>
<th>Core 10. Implements One Clinical Decision Support Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 348</td>
</tr>
<tr>
<td>37% Yes, Ready Now</td>
</tr>
<tr>
<td>17% Yes, Ready By 2012</td>
</tr>
<tr>
<td>25% No, Not Ready By 2012</td>
</tr>
<tr>
<td>21% Unsure</td>
</tr>
</tbody>
</table>
Core 11: Reporting on Clinical Quality Measures

Nineteen percent of the respondents identified that they can report on ambulatory clinical quality measures now and 27% will be able to report on quality measures by 2012. There will need to be more analysis of the 21% that will not be ready by 2012 and the 32% that are unsure. See Chart 31.

Chart 31

< ![Core 11. Reports Ambulatory Clinical Quality Measures](chart1.png) >

Core 12: Electronic Health Information for Patients

Only 16% of the respondents identified that they are now able to provide patients with an electronic copy of their health information and 34% indicated that they will be able to meet this criteria in 2012. Twenty-nine percent identified that they will not be ready in 2012 and another 21% indicated they are unsure. See Chart 32.

Chart 32

< ![Core 12. Provides Patients with an Electronic Copy of their Health Information](chart2.png) >
Core 13: Clinical Summaries to Patients

Nineteen percent of respondents can now provide clinical summaries for patients after each office visit and 32% indicated that they will be able to do this by 2012. Twenty-eight percent indicate they will not be ready in 2012 and 21% indicated that they are unsure. See Chart 33.

Chart 33

Core 14: Exchange of Key Clinical Information Among Providers

Twenty-five percent of the respondents identified that they can now exchange key clinical information with other healthcare providers and 33% indicated that they will be able to exchange information in 2012. Twenty-five percent identified that they will not be able to exchange key clinical information by 2012, and 17% are unsure. See Chart 34.

Chart 34
Core 15: Protects Electronic Health Information

More than 80% of the respondents indicated that they are able to protect electronic health information, with 61% being able to do this now and another 21% being ready by 2012. Ten percent indicated they will not be ready by 2012 and 8% identified that they are unsure. See Chart 35.

Chart 35

MEANINGFUL USE MENU SET MEASURES

Menu 1: Electronic Data to Immunization Registries

Only 8% of respondents identified that they can submit data electronically to immunization registries now and 18% indicated that they will be able to meet this criteria by 2012. Thirty-six percent indicated they will not be ready by 2012 and 38% indicated they are unsure if they will be able to meet the criteria. See Chart 36.

In most cases behavioral health organizations would not be reporting immunizations so even if they have a certified system they would not have this function activated.

Chart 36
Menu 2: Syndromic Surveillance Data to Public Health Agencies

Only 6% of respondents identified that they are able to submit syndromic surveillance data now and 18% indicated they can do this by 2012. Thirty-five percent of the respondents indicated they would not be able to meet this criteria by 2012 and 41% indicated they were unsure if they would meet this criteria.

This is not a surprising response as behavioral health organizations would not normally be collecting data from their clients that would be reportable to public health agencies. As we move further into integrated models of care, the response to this question and to Menu 1 should change as behavioral health organizations begin to provide integrated physical health services. See Chart 37.

Chart 37
Menu 3: Drug Formulary Checks

Twenty-four percent of the respondents indicated that they can implement drug formulary checks now and 26% indicated they can meet the criteria in 2012. Twenty-five percent reported they would not be able to meet the criteria by 2012 and another 25% indicated they were unsure if they would be able to meet the criteria. See Chart 38.

Chart 38

Menu 3. Implements Drug Formulary Checks  
N = 353

Menu 4: Incorporation of Clinical Lab Test Results

Twenty-one percent of the respondents identified they are now able to incorporate clinical lab test results as structured and 30% indicated they would be able to meet the criteria by 2012. Twenty-six percent indicated that they would not be able to meet the criteria by 2012 and 23% indicated that they were unsure if they could meet the criteria. See Chart 39.

Chart 39

Menu 4. Incorporates Clinical Lab Test Results as Structured Data  
N = 344
Menu 5: Patient Lists by Specific Conditions

Sixty percent of the responding organizations identified that they could generate lists of patients by specific conditions for quality improvement and outreach, now or by 2012. Thirty-five percent indicated that they can meet the criteria now and 25% indicated they would be able to meet the criteria by 2012. Twenty-one percent indicated that they would not be able to meet the criteria by 2012 and 19% indicated that they were unsure if they will be able to meet the criteria. See Chart 40.

Generating lists of patients by specific conditions is the first step in monitoring and managing an organization’s service population yet it is concerning that 40% of behavioral health organizations will not be able to do this by the end of 2012.

Chart 40

Menu 5. Generates Lists of Patients by Specific Conditions for QI, Outreach
N = 355

- Yes, Ready Now: 35%
- Yes, Ready By 2012: 21%
- No, Not Ready By 2012: 19%
- Unsure: 25%
**Menu 6: Patient Reminders for Preventive/Follow Up Care**

Only 14% of the respondents identified that they are able to meet the criteria and send reminders to patients for preventive/follow up care now and 27% indicated they will be able to do so in 2012. Thirty-four percent do not expect to be able to meet the criteria by 2012 and 25% are unsure if they will be able to meet the criteria. See Chart 41.

This is an area that will need further exploration for the 59% that will not meet the criteria or are unsure. We would expect and encourage all behavioral health organizations to have the capability to send reminders to patients for preventive or follow up care even if not meeting MU criteria.

**Chart 41**

<table>
<thead>
<tr>
<th>Menu 6. Sends Reminders to Patients for Preventive / Follow-up Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 347</td>
</tr>
<tr>
<td>14% Yes, Ready Now</td>
</tr>
<tr>
<td>25% Yes, Ready by 2012</td>
</tr>
<tr>
<td>27% No, Not Ready by 2012</td>
</tr>
<tr>
<td>34% Unsure</td>
</tr>
</tbody>
</table>
Menu 7: Patient Access to Health Information

Only 12% of respondents identified that they can provide patients with timely electronic access to their health information and 28% indicated that they will be able to meet this criteria in 2012. Thirty-four percent of the respondents identified that they do not expect to meet the criteria in 2012 and 26% are unsure if they will be able to meet the criteria. See Chart 42.

Chart 42

Menu 8: Patient-specific Education Resources

Twenty-two percent of the respondents identified they now provide patient-specific education resources if appropriate and 29% identified that they will be able to meet the criteria in 2012. Twenty-three percent of the respondents identified that they will not be able to meet the criteria in 2012 and 25% identified that they are unsure if they will be able to meet the criteria. See Chart 43.

Chart 43
Menu 9: Medication Reconciliation at Transfers of Care

Twenty-two percent (22%) of respondents identified that they can now perform medication reconciliation at relevant transfers of care and 23% identified they will be able to meet the criteria in 2012. Twenty-four percent (of respondents identified that they would not meet the criteria in 2012 and 31% identified that they were unsure if they would be able to meet the criteria. See Chart 44.

Chart 44

Menu 10: Summary of Care Records

Twenty-eight percent of the respondents identified that they can currently provide a summary of care record for each transition of care or referral and 28% identified they expect to meet the criteria in 2012. Twenty percent identified they will not be ready by 2012 and 23% identified they are unsure if they will be able to meet the criteria. See Chart 45.

Chart 45
Meaningful Use Readiness: Pieces are not the Whole

While respondents indicated that they are able to meet one or more specific MU core measures and menu set measures, most are unable to meet the full set of MU criteria at the level required to receive incentive payments.

Only 7% (33 organizations) of respondents will meet MU criteria now or by the end of 2012. Two percent of respondents indicated that they could meet all 15 MU Core Measures and at least five Menu Set Measures at the time they responded to the survey and 5% indicated that they could meet MU by the end of 2012. See Chart 46.

Note that 13 respondents did not have an EHR at the time they completed the survey but had identified a vendor and were committed to meeting the criteria by the end of 2012.
Meaningful Use Readiness vs. EHR Implementation Status

Twenty four percent of all responding organizations identified that they have an EHR and are all electronic at all their sites — however, only 11% of these organizations are able to meet MU criteria by 2012. See Chart 47.

Chart 47

Meaningful Use Readiness vs. EHR Implementation Status

11% Will Meet MU by 2012
89% Will Not Meet MU by 2012

Having an EHR, having it deployed at all sites, and being paperless are not good indicators of an organization’s ability to use HIT in a meaningful and effective manner. This merits further investigation into the characteristics of these organizations, how they are using their systems, vendor relationships, current software version and costs of upgrading, and other factors. These organizations may require significant training and technical assistance to meet MU requirements by the end of 2012.
Meaningful Use Readiness and Staff Size

Organizations with more than 500 FTEs seemed to be better able to meet MU by the end of 2012 — eleven percent of 65 organizations in this category indicated they can meet MU, while less than 4% of the 46 organizations with 25 or fewer FTEs indicated that will be able to meet MU by the end of 2012. See Chart 48.

Chart 48

Meaningful Use Readiness and Total Operating Budget

Readiness for MU is not significantly different for organizations with different total operating budgets. Organizations with budgets over $10 million were a little more likely to be ready than organizations with budgets under $10 million. See Chart 49.

Chart 49
Meaningful Use Readiness and Type of Organization

Inpatient Substance Abuse Facilities at 5% are less likely to be ready than other types of organizations, which ranged from 8% to 9%. See Chart 50.

Chart 50

Meaningful Use Readiness and Type of Organization

<table>
<thead>
<tr>
<th>Type of Organization</th>
<th>Readiness %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Mental Health Center (non-profit)</td>
<td>8%</td>
</tr>
<tr>
<td>Outpatient Substance Abuse Organization (non-profit)</td>
<td>7%</td>
</tr>
<tr>
<td>Residential (Mental Health)</td>
<td>9%</td>
</tr>
<tr>
<td>Residential (Substance Abuse)</td>
<td>8%</td>
</tr>
<tr>
<td>Inpatient (Mental Health)</td>
<td>9%</td>
</tr>
<tr>
<td>Inpatient (Substance Abuse)</td>
<td>5%</td>
</tr>
</tbody>
</table>

Meaningful Use Readiness and Number of Services Provided

Ten percent of organizations providing three or more services indicated that they would be able to meet MU by 2012 while only 5% of organizations providing one or two services indicated they would be ready. See Chart 51.

Chart 51

Meaningful Use Readiness and Number of Services Provided

<table>
<thead>
<tr>
<th>Number of Services</th>
<th>Readiness %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Service</td>
<td>5%</td>
</tr>
<tr>
<td>2 Services</td>
<td>5%</td>
</tr>
<tr>
<td>3+ Services</td>
<td>10%</td>
</tr>
</tbody>
</table>
Meaningful Use Readiness and Funding Source

Funding source did not seem to be a determining factor in an organization's readiness for MU. See Chart 52.

See Chart 52

Meaningful Use Readiness and Location

There was a small difference in readiness for MU by type of geographic location with urban sites at 6%, rural sites at 7%, and organizations that were in both urban and rural locations at 10%. See Chart 53.

Chart 53
Meaningful Use Readiness and Onsite Primary Care Services

Having onsite primary care services did not seem to be an indicator of readiness for MU. Seven percent of sites without primary care services and 9% of sites with primary care services indicated they would be ready for MU by 2012. See Chart 54.

Chart 54

Meaningful Use Readiness and Onsite Primary Care Services

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Primary Care</td>
<td>7%</td>
</tr>
<tr>
<td>Onsite</td>
<td></td>
</tr>
<tr>
<td>Have Primary Care</td>
<td>9%</td>
</tr>
<tr>
<td>Onsite</td>
<td></td>
</tr>
</tbody>
</table>
Not Ready for Specific Meaningful Use Criteria

Although 50% of behavioral health organizations that responded to this survey can meet one or more specific MU criteria now or in 2012, 40-50% of respondents are not able to meet — or are unsure if they can meet — each of 10 MU Core Measures or 15 Menu Set measures by 2012. The most common criteria that these organizations cannot meet are indicated in the chart below. See Chart 55.

More analysis is required to obtain a better profile of these organizations and the impediments to meeting MU criteria.

Chart 55
Difficulty in Meeting Specific Meaningful Use Criteria

Twenty seven organizations that identified they are close to meeting some of the specific MU criteria but are challenged in meeting several other criteria. For instance, 22% of these 27 organizations could not meet criteria for reporting clinical quality measures. Fifteen percent of the organizations identified that using Computerized Provider Order Entry and providing patients with an electronic copy of their medical record were not attainable by 2012. Eleven percent of the 27 organizations also identified providing patients with clinical summaries after each visit as well as exchanging key clinical information as difficulties. See Chart 56.

Chart 56

Difficulties in Meeting Specific Meaningful Use Criteria

(N = 27)

<table>
<thead>
<tr>
<th>Core</th>
<th>Not Ready by 2012</th>
<th>Unsure</th>
<th>Total Not Ready or Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core 8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core 9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core 10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core 11</td>
<td></td>
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<td></td>
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<tr>
<td>Core 12</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Core 13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core 14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core 15</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Patient Access to Personal Health Records

Over a quarter (28%) of respondents identified that their patients have access to a Personal Health Record. See Chart 57.

Chart 57

![Patient Access to Personal Health Record](chart57.png)

Personal Health Record and Electronic Health Record Linkage

Thirty-four percent of respondents to this question identified that the Personal Health Record is linked to the EHR. See Chart 58.

Chart 58

![Personal Health Record and Electronic Health Record Linkage](chart58.png)
Barriers to Use of Personal Health Records

Perceived barriers to patients’ use of Personal Health Records are lack of the computer literacy (64%), lack of patient interest (54%), lack of provider interest (23%), lack of English proficiency of patients (19%), and other reasons such as cost, lack of priority, and lack of expertise in the organization (22%). See Chart 59.

Chart 59

<table>
<thead>
<tr>
<th>Barriers to Use of Personal Health Records</th>
<th>N = 324</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer Literacy of our clients</td>
<td>64%</td>
</tr>
<tr>
<td>English language proficiency of our clients</td>
<td>54%</td>
</tr>
<tr>
<td>Lack of Patient interest in using a PHR</td>
<td>23%</td>
</tr>
<tr>
<td>Lack of Provider interest</td>
<td>19%</td>
</tr>
<tr>
<td>Other</td>
<td>22%</td>
</tr>
</tbody>
</table>

Interest in EHR Implementation Collaborative

When asked if they would be interested in participating in an EHR implementation collaborative, 26% of respondents identified that they would be interested. See Chart 60.

Chart 60

<table>
<thead>
<tr>
<th>Interest in EHR Implementation Collaborative</th>
<th>N = 381</th>
</tr>
</thead>
<tbody>
<tr>
<td>We have formed or are currently in the process of forming an EHR collaborative</td>
<td>19%</td>
</tr>
<tr>
<td>We have no interest in an EHR collaborative</td>
<td>37%</td>
</tr>
<tr>
<td>We would like to form an EHR collaborative but need more information</td>
<td>19%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>26%</td>
</tr>
</tbody>
</table>
Recommendations

A study by the Substance Abuse and Mental Health Services Administration points to a strikingly high incidence of cancer, heart disease, diabetes, and asthma among the more than 8 million Americans served by the public mental health and addiction treatment system. Clearly, individuals with mental health and substance use conditions are in dire need of care coordination. The Office of the National Coordinator’s Federal HIT Strategic Plan includes support for HIT adoption in behavioral health settings among strategies to promote meaningful use of HIT, noting that, “the ability to integrate mental health data into the primary care and related safety net systems is essential for coordinating care.”

Health IT is the bedrock of any effort to coordinate and integrate care for persons with mental and addiction disorders and multiple and chronic physical illnesses. Yet, mental health and addictions treatment organizations face significant financial challenges in trying to adopt comprehensive EHR systems, and fewer than 30% have been able to implement full or partial EHR systems.

If behavioral health organizations cannot adopt health IT at a rate comparable with primary care facilities, hospitals, and physicians, it will soon become impossible to provide clinical care coordination. Persons with serious mental illnesses are a high cost patient population and federal government efforts to reduce health spending through health homes and accountable care organizations, and state efforts to enroll dual eligibles in integrated managed care settings will be compromised if behavioral health organizations remain excluded from MU incentive facility payments. The National Council recommends the following actions by various entities to support HIT adoption and Mu readiness by behavioral health organizations:

**Recommendations for Congress**

- Stop the advancing digital divide for behavioral health organizations. Align behavioral health organizations with other healthcare providers and provide health information technology incentive dollars for them. We recommend passage of S. 539, the Behavioral Health Information Technology Act of 2011, to provide behavioral health organizations with the same incentives as their medical counterparts.

**For the Office of the National Coordinator**

- Provide targeted funding to behavioral health organizations in Beacon Community Grant programs where the behavioral health provider is the lead organization.
- Ensure that all state Health Information Exchanges (HIEs) include behavioral health organizations.
• Provide targeted funding to behavioral health organizations around care coordination and health information exchange. Disease Registries and other Care Coordination tools through HIEs can provide a less expensive stop gap until full funding is available. This funding needs to be targeted to behavioral health.
• Incentivize Regional Extension Centers to support behavioral health organizations. Behavioral health organizations are not considered a target provider by most RECs and they do not receive the same level of intensive service that medical providers receive.
• Support a program to utilize the products developed under the Curriculum Development Centers Program and extend the Community College Curriculum and the Health Information Technology Competency Examination Programs to behavioral health organizations.

For SAMHSA
• Build on current infrastructure and proven methods.
• Expand SAMHSA’s Learning Collaborative model to behavioral health organizations — this method has been used effectively and efficiently widely by SAMHSA, HRSA and the National Council.
• Focus the existing HRSA Health Center Controlled Networks (HCCNs) program to behavioral health organizations. HRSA has invested more than $100 million over the years to help Federally Qualified Health Centers (FQHCs) to implement technology and HCCNs have shown to be a proven model for EHR adoption. Almost all FQHCs will have EHRs by 2012. We encourage SAMHSA, HRSA and ONC to develop targeted funding specific to behavioral health organizations utilizing selected HCCNs.

For EHR Vendors
• Provide lower cost entry level systems that focus on care coordination and health information exchange with the data being portable to any EHR in the future.
National Council Initiatives

The National Council has responded to the needs of behavioral health organizations through the development of its Value in Technology program. The program offers webinars with hands-on implementation guidance and access to experts; consultants who can assist behavioral health organizations in meeting their HIT goals; discounts on HIT products and services; and a mechanism for onboarding behavioral health organizations to the DIRECT Secure Messaging platform, allowing them to communicate with other medical providers meeting MU.

The National Council is also preparing to launch HIT collaboratives to help behavioral health organizations overcome barriers to HIT adoption and implementation.

The National Council is positioned to work with federal, academic, nonprofit and for-profit partners to lead the way to help behavioral health organizations keep up with their medical counterparts in rapid adoption of HIT.
Acknowledgements

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