Form Approved  
OMB No. 0990-xxx

Expiration Date: xx/xx/xx

**The National Council for Behavioral Health’s**

**Information Technology Survey**

***PLEASE READ BEFORE COMPLETING THE QUESTIONNAIRE***

Most of the questions in this survey ask about your organization. If you have any questions about how the term “organization” applies, please call 202-774-1656 or email [BHITSHelp@thenationalcouncil.org](mailto:BHITSHelp@thenationalcouncil.org).

* Please answer ONLY for the organization whose name and location are indicated, unless otherwise specified in the questionnaire.
* Please keep a copy of your completed questionnaire for your records.
* If you have questions, contact:

The National Council for Behavioral Health

1400 K Street NW | Suite 400 | Washington, D.C. 20005

202-774-1656

[adrianoB@thenationalcouncil.org](mailto:adrianoB@thenationalcouncil.org)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990-xxxx. The time required to complete this information collection is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer

**SECTION A: ELIGIBILITY TO PARTICIPATE IN THE SURVEY**

**1. Do you have the knowledge and/or experience to answer questions about your organization’s use of health information technology, such as electronic health records?**

* + Yes—Continue to section B
  + No

If not, please forward the invitation to the individual within your organization who can answer these questions.

**SECTION B: ORGANIZATION CHARACTERISTICS**

This section asks about characteristics of your organization.

**1. Which of the following categories describes your organization? Check all that apply.**

* Psychiatric hospital
* Separate inpatient psychiatric unit of a general hospital
* Inpatient substance use treatment
* Residential treatment center for children
* Residential treatment center for adults
* Other type of residential treatment organization
* Veterans Administration medical center (VAMC) or other VA health care organization
* Community mental health center (CMHC)
* Partial hospitalization/day treatment organization
* Outpatient mental health organization
* Outpatient substance use organization
* Multi-setting mental health organization (nonhospital residential plus either outpatient and/or partial hospitalization/day treatment)
* Federally Qualified Health Center (FQHC)
* Solo or small group practice
* Jail, prison, or detention center that provides treatment exclusively for incarcerated persons or juvenile detainees
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. What is the primary treatment area(s) of your organization? Check all that apply.**

* Mental health treatment
* Substance use treatment
* Mix of mental health and substance use treatment (neither is primary)
* General health care
* Other service focus (Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**3. Is this organization operated by (Check one response only):**

* A private for-profit organization
* A private non-profit organization
* A public agency or department

**4. Is your organization part of a larger health system? Check one response only.**

* + Yes
  + No

**5. What age groups are accepted for treatment at this organization? Check all that apply.**

* + Children (12 years or younger)
  + Adolescents (13-17 years)
  + Young adults (18-25)
  + Adults (26-64 years)
  + Older Adults (over 64 years)

**6. Please indicate the number of full-time equivalents (FTEs) that work in your organization:**

* + 0-25
  + 26-100
  + 101-250
  + 251-500
  + 501+

**7. What is the approximate volume of patient/client encounters that occur annually at your organization?**

* + Fewer than 1,000
  + 1,000-4,999
  + 5,000-9,999
  + 10,000-24,999
  + 25,000-49,999
  + 50,000 or more
  + My organization does not provide direct care or services to individuals
  + I don’t know

**8. Please indicate your organization’s funding sources (check all that apply)**

* + Community Mental Health Block Grants
  + Community Service Block Grants
  + Other Block Grants (e.g. substance abuse, prevention)
  + Federal Discretionary Funds
  + Medicaid
  + Medicaid Managed Care
  + Medicare
  + Federal military insurance such as Tricare
  + IHS/Tribal/Urban (ITU) funds
  + Self Pay/Cash
  + Uninsured
  + Private Health Insurance/HMO
  + State-financed health insurance plan other than Medicaid
  + State mental health agency (or equivalent) funds
  + State welfare or child and family services agency funds
  + State corrections or juvenile justice agency funds
  + State education agency funds
  + Other state government funds
  + County or local government funds
  + U.S. Department of Veterans Affairs funds
  + Other Grants
  + Other (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Do you participate in any of the following Delivery System Reform Initiatives or Models (check all that apply)?**

* + Patient Centered Medical Home or Health Home
  + Accountable-Care Organization
  + Value Base Payment Contract
  + Other

**10. Does your organization have on site health IT (Information Technology) staff and/or a Director of IT/MIS (Management Information Systems) or CIO (Chief Information Officer)? *Check all that apply.***

* + Yes, full time staff person
  + Yes, part-time staff person
  + Yes, full time Director or CIO
  + Yes, part-time Director or CIO
  + No, but available through a service contract
  + No

**11a. What is your role within the organization?**

* Senior Executive within organization (e.g. Director, Chief Executive Officer)
* Chief Information Technology Officer
* Other IT staff role
* Grant Program Director
* Grant Program Manager
* Other (please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**11b. Please provide your contact information (note: this information will only be used to contact you if necessary, to ensure response validity and reliability of the responses):**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_ -

Email Address:

**12. Which SAMHSA grantee program(s) does your organization participate? Check all that apply.**

* + Screening Brief Intervention and Referral to Treatment (SBIRT)
  + Grants to Expand Care Coordination Targeted Capacity Expansion (TCE) Through the use of Technology-Assisted Care (TAC) in Targeted Areas of Need
  + Medication Assisted Treatment (MAT) – Prescription Drug and Opioid Addiction (PDOA)
  + Offender Re-Entry Program (ORP)
  + Cooperative Agreement to Benefit Homeless Individuals (CABHI)
  + Minority Serving Institutions (MSIs) partnerships with Community-Based Organizations (CBOs)
  + HIV Capacity Building Initiative (CBI)
  + Primary Behavioral Health Care Integration (PBHCI)
  + National Child Traumatic Stress Initiative (NCTSI)
  + Garrett Lee Smith Youth Suicide Prevention Program (GLS
  + None of the above
  + Don’t know

**13. If available, please provide your grantee identification number below.**

**Section C: EHR adoption**

**1. Does your organization use an electronic health record (EHR)? Do not include billing record systems.**

* + Yes, we exclusively use an EHR. No paper charts.
  + Yes, we use a combination of an EHR and paper charts.
  + No, but we plan to implement an EHR— Skip to item #9 (EHR barriers section)
  + No, and we have no plan to implement an EHR—Skip to item #9 (EHR barriers section)

**1a**. **If your organization uses an EHR, please indicate whether EHRs are used across all or some facilities within your organization.**

* We use EHRs across all the facilities/sites within our organization
* We use EHRs across some of the facilities/sites within our organization
* Not applicable (e.g. only one facility within organization)
* Do not know

**1b.** **Which types of facilities within your organization use an EHR (either fully or partially)? Select all that apply.**

* Psychiatric hospital
* Separate inpatient psychiatric unit of a general hospital
* Inpatient substance use treatment
* Residential treatment center for children
* Residential treatment center for adults
* Other type of residential treatment organization
* Veterans Administration medical center (VAMC) or other VA health care organization
* Community mental health center (CMHC)
* Partial hospitalization/day treatment organization
* Outpatient mental health organization
* Outpatient substance use organization
* Multi-setting mental health organization (nonhospital residential plus either outpatient and/or partial hospitalization/day treatment)
* Federally Qualified Health Center (FQHC)
* Solo or small group practice
* Jail, prison, or detention center that provides treatment exclusively for incarcerated persons or juvenile detainees
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Please indicate the name of your EHR system vendor(s). Please select all that apply across your organization.**

* + Accumedic
  + AMS
  + Askesis
  + Cerner
  + Co-Centrix
  + E-Clinical Works
  + Core Solutions
  + Credible Behavioral Healthcare Software
  + Echo Group
  + EPIC
  + GE
  + Methasoft
  + Meditech
  + Methware
  + Netanalytics
  + Netsmart
  + NextGen
  + Profiler
  + Qualifacts
  + Smart Management
  + SAMS
  + Tower Systems
  + Valant
  + Welligent
  + Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + Don’t know

**3. Does your organization use a certified EHR system?**  ***Certified EHRs*** *are tested and certified by the Office of the National Coordinator for Health IT certification program and their use may meet the criteria for Meaningful Use in the EHR Incentive Program. These products are listed in the* [***Certified Health Information Technology Product List***](http://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl).

□1 **Yes** □2 **No** □3 **Do not know**

**4. Do eligible clinicians (e.g. psychiatrists, other physicians and nurse practitioners) in your organization participate in the CMS (Medicaid or Medicare) EHR Incentive Program (Meaningful Use)?**

□1 Yes

□2 No

□3 Not applicable--we don’t have any eligible providers working in our organization

□4 Don’t know

**5. Does your organization use your EHR to record any of the following elements of a clients’ chart? *Check all that apply.***

□1 Intake assessment

□2 Behavioral health screenings or tools

□3 Treatment plans

□4 Monitoring client progress

□5 Discharge plans

□6 Referrals

□7 Don’t know

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 6. Does your organization use your EHR to:  *CHECK ONLY ONE BOX PER ROW.* | **Yes** | **No** | **Don’t know** | **NA** |
| **Record patient history and demographic information?** | □1 | □2 | □3 | □4 |
| **Record social and behavioral determinants of health (employment, housing)** | □1 | □2 | □3 | □4 |
| **Record clinical notes?** | □1 | □2 | □3 | □4 |
| **Record patients’ medications and allergies?** | □1 | □2 | □3 | □4 |
| Record problem lists? | □1 | □2 | □3 | □4 |
| Order prescriptions? | □1 | □2 | □3 | □4  *x* |
| Electronically send prescriptions to the pharmacy? | □1 | □2 | □3 | □4 |
| Review warnings of medication allergies, drug-drug interactions or contraindications? | □1 | □2 | □3 | □4 |
| Reconcile medications when admitting, discharging, and/or transitioning clients between care settings? | □1 | □2 | □3 | □4 |
| Order lab tests? | □1 | □2 | □3 | □4 |
| View lab results? | □1 | □2 | □3 | □4 |

**Client Access to their Medical Records**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 7. Does your EHR allow clients to… | Yes | No | Don’t Know | NA |
| 1. **Exchange secure messages with your clinicians/counselors?** | □1 | □2 | □3 | □4 |
| 1. **Electronically view their medical record (e.g. health and behavioral health information) online?** | □1 | □2 | □3 | □4 |
| 1. **Download their medical record?** | □1 | □2 | □3 | □4 |

**Benefits and Barriers of EHR adoption**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 8. Has your organization’s use of EHR system… | Yes | No | Don’t know | NA |
| **Enhanced overall care for clients?** | 1□ | 2□ | 3□ | 4□ |

| **9. Which of the following were or are barriers to adopting an EHR system experienced by your organization? Indicate all those that apply.** | **Yes** | **No** | **Do not know** |
| --- | --- | --- | --- |
| **a. Finding an EHR system that meets your organization’s needs** | 1□ | 2□ | 3□ |
| **b. Limited or lack of IT staff to support EHR adoption** | 1□ | 2□ | 3□ |
| **c. Cost of purchasing and maintaining an EHR system** | 1□ | 2□ | 3□ |
| **d. Loss of productivity during the transition to an EHR system** | 1□ | 2□ | 3□ |
| **e. Staff resistance to use EHR** | 1□ | 2□ | 3□ |
| **f. Interstate professional licensing issues** | 1□ | 2□ | 3□ |
| **g. Privacy or security concerns** | 1□ | 2□ | 3□ |

**Section D. Interoperability and Exchange**

**1. Does your organization ONLY use paper-based methods (e.g. fax or mail) to send AND receive patient health information with providers outside your organization?**

🞏**Yes (Skip to #13, question on barriers to interoperability)** 🞏**No** 🞏**Don’t Know**

**2. When a patient transitions to another provider outside your organization, does your organization routinely send patient health information (e.g. labs, medications, summary of care records) using any of the following methods? *Check all that apply***

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Don’t know** |
| Mail or fax | 🞏 | 🞏 | 🞏 |
| eFax using EHR | 🞏 | 🞏 | 🞏 |
| Secure messaging (via DIRECT or other secure protocol) | 🞏 | 🞏 | 🞏 |
| Provider portal (i.e., post to portal or download from portal) | 🞏 | 🞏 | 🞏 |
| Via health information exchange organization or other third party | 🞏 | 🞏 | 🞏 |
| Interface connection with other EHRs | 🞏 | 🞏 | 🞏 |
| Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 | 🞏 | 🞏 |

**3. When a patient transitions from another provider outside your organization, does your organization routinely receive patient health information (e.g. labs, medications, summary of care records) using any of the following methods? *Check all that apply***

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Don’t know** |
| Mail or fax | 🞏 | 🞏 | 🞏 |
| eFax using EHR | 🞏 | 🞏 | 🞏 |
| Secure messaging (via DIRECT or other secure protocol) | 🞏 | 🞏 | 🞏 |
| Provider portal (i.e., post to portal or download from portal) | 🞏 | 🞏 | 🞏 |
| Via health information exchange organization or other third party | 🞏 | 🞏 | 🞏 |
| Interface connection with other EHRs | 🞏 | 🞏 | 🞏 |
| Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 | 🞏 | 🞏 |

**4. Does your organization electronically send and/or receive summary of care documents in a structured format with providers outside your organization on a routine basis?** *Note: Electronic excludes e-Fax or scanned documents. An example of a summary of care document includes a Continuity of Care Document (CCD).*

* Yes, send only
* Yes, receive only
* Yes, send and receive
* No, neither send nor receive
* Do not know
* Not applicable

**5. Do staff within your organization electronically search or query for clients’ health information (e.g., medications, outside encounters) from providers or other sources outside your organization?** *Electronic does not refer to e-Fax or scanned documents.*

|  |  |  |  |
| --- | --- | --- | --- |
| 🞏 Yes | 🞏No, but do have the capability | 🞏 No, don’t have capability | 🞏 Do not know |

**5a. How do staff electronically search or query for clients health information from sources outside your organization?**

🞏 Tool within EHR to view external results

🞏 Tool within EHR to view external results provided by HIE (HIE sign on)

🞏 Tool outside of EHR (e.g. portal) to view external results

🞏 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Do not know

**6. Does your EHR integrate or incorporate any type of clinical information (e.g. medications, lab test results) that is received electronically from providers outside your organization without the need for manual entry?** *Electronic does not refer to e-Fax or scanned documents.*

🞏 1 Yes 🞏 2 No 🞏 3 Do not know

**Mechanisms to enable exchange**

**7. What type of vendor does your organization use to electronically exchange patient health information with providers outside your organization? *Check all that apply*.**

**□1 EHR vendor**

**□2 Vendor other than EHR vendor (e.g. HIE vendor)**

**□3 Don’t know**

**□4 None**

**□5 NA**

**8. Please indicate your level of participation in a state, regional, and/or local health information exchange (HIE) or health information organization (HIO).**

1. 🞏 HIE/HIO is operational in my area and we are participating and actively exchanging data in at least

one HIE/RHIO

1. 🞏 HIE/HIO is operational in my area but we are not participating
2. 🞏 HIE/HIO is not operational in my area
3. 🞏 Do not know

**Benefits and Barriers to Interoperability**

**9. Do providers at your organization routinely have necessary clinical information (e.g. medications, lab tests) available electronically (not e-Fax) from outside providers or sources when treating a patient that was seen by another health care provider/setting?**

|  |  |  |
| --- | --- | --- |
| 🞏 Yes | 🞏 No | 🞏 Do not know |

**10. How frequently do providers at your organization use patient health information (e.g. medications, lab test results) received electronically (not e-Fax) from outside providers when treating a patient?**

🞏 Often 🞏 Sometimes 🞏 Rarely 🞏 Never 🞏 Do not know

10a. If rarely or never used, please indicate the reason(s) why. Check all that apply.

1. 🞏 Information not always available when needed (e.g. not timely)
2. 🞏 Do not trust accuracy of information
3. 🞏 Difficult to integrate information in EHR
4. 🞏 Information not available to view in EHR as part of clinicians’ workflow
5. 🞏 Information not presented in a useful format (e.g. too much, redundant, or unnecessary

information)

1. 🞏 Information not useful
2. 🞏 Do not know

**11. Please indicate whether your organization has experienced benefits from electronically exchanging health information with providers outside your organization.** *Note: Electronic health exchange refers to electronically sending, receiving, finding or integrating patient health information.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | No | Don’t know | NA |
| a. Improved quality of care | □1 | □2 | □3 | □4 |
| b. Increased efficiency | □1 | □2 | □3 | □4 |
| c. Increased patient safety (e.g. reductions in medication errors) | □1 | □2 | □3 | □4 |
| d. Reduced duplicate test ordering | □1 | □2 | □3 | □4 |
| e. Enhanced care coordination with providers outside our organization | □1 | □2 | □3 | □4 |

**12. Which of the following were or are barriers to electronic health information exchange has your organization experienced?** *Note: Electronic health information exchange refers to electronically sending, receiving, finding or integrating patient health information.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | No | Don’t know | NA |
| a. Electronic exchange is cumbersome to do with our EHR | □1 | □2 | □3 | □4 |
| b. Electronic exchange requires the use of multiple systems or portals | □1 | □2 | □3 | □4 |
| c. Electronically exchange is more challenging with facilities whose EHR differs from ours. | □1 | □2 | □3 | □4 |
| d. Providers in our referral network lack the electronic capability to exchange. | □1 | □2 | □3 | □4 |
| e. There are additional costs to electronically exchange. | □1 | □2 | □3 | □4 |
| f. We lack the technical capability to electronically exchange (e.g. lack EHR, lack HIE connection) | □1 | □2 | □3 | □4 |
| g. Concerns about the privacy and security of health information that is exchanged | □1 | □2 | □3 | □4 |
| h. Concerns about being able to separate sensitive health information | □1 | □2 | □3 | □4 |
| i. Burden associated with obtaining and maintaining patient consent for exchange | □1 | □2 | □3 | □4 |
| j. Lack staff and resources to support electronic exchange of information | □1 | □2 | □3 | □4 |
| k. Do not perceive value from electronic health information exchange | □1 | □2 | □3 | □4 |
| l. Legal restrictions on exchange of patient information (e.g. HIPAA, state laws) | □1 | □2 | □3 | □4 |

**Section E. Use of Other Types of Health IT**

**1. Do staff use any of the following types of technology to provide clients services?**

□1 [**Telehealth**](#DefinitionTelehealth)**.** *Telehealth refers to the use of electronic information and telecommunication technologies (e.g. such as telephone, email and web-assisted videoconferencing) to support long-distance clinical health care.*

□2 [**Mobile technolog**](file:///G:\Office%20of%20Planning%20Evaluation%20&amp;%20Analysis\R&amp;E%20-%20Work%20Plan%20Strategy\Behaviorial%20Health\Attachment%201_Survey%20Questions_052215.docx#DefinitionmHealth)**ies**.*Mobile technologies refers to the use of mobile devices, Smartphone apps, client monitoring devices and/or other wireless devices for health-related services and/or communications.*

□3 **Don’t Know**

□4 **NA**

**2. Do clients use mobile technology to participate in their prevention, treatment, and/or recovery?** *Mobile technologies refers to the use of mobile devices, Smartphone apps, client monitoring devices and/or other wireless devices for health-related services and/or communications.*

**□1 Yes □2 No □3 Don’t know □4 NA**

**Thank you for completing the survey!**