Behavioral Health
Health Information Technology
Learning Collaborative

We will start the event momentarily. While you wait, please respond to our icebreaker poll.

Oregon Health Authority

Learning Collaborative Audience

- 184 registrants
  - 102 organizations
  - 25 EHRs; most common:
    - Epic
    - Credible
    - Qualifacts
    - DrCloud
    - Netsmart
  - Role/department
    - 46% Management/ Administration
    - 22% IT
    - 15% Other
    - 9% User/Staff
    - 8% Provider

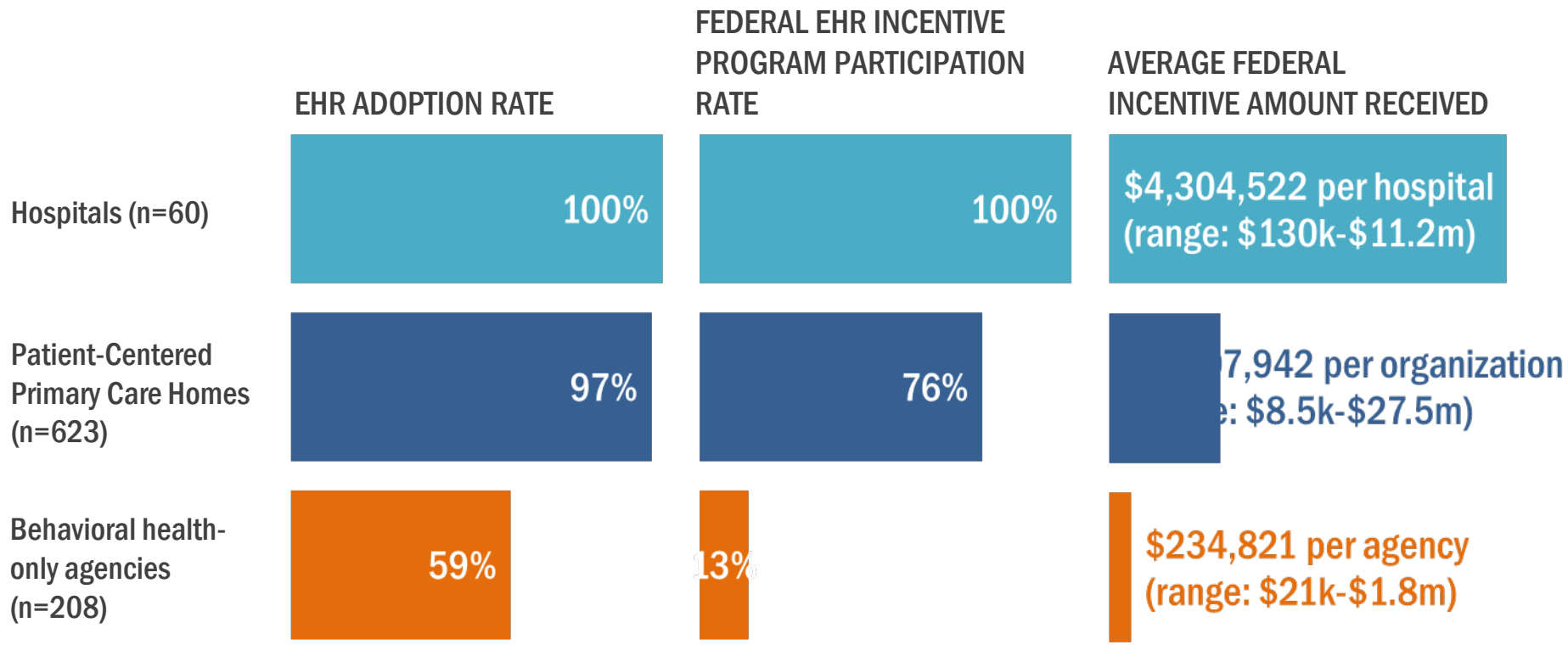
Oregon Health Authority

Behavioral Health EHR Utilization in Oregon

September 1, 2020

Oregon Health Authority - Office of Health Information Technology

OREGON EHR ADOPTION IS VERY HIGH OVERALL, BUT DIGITAL DIVIDES EXIST.

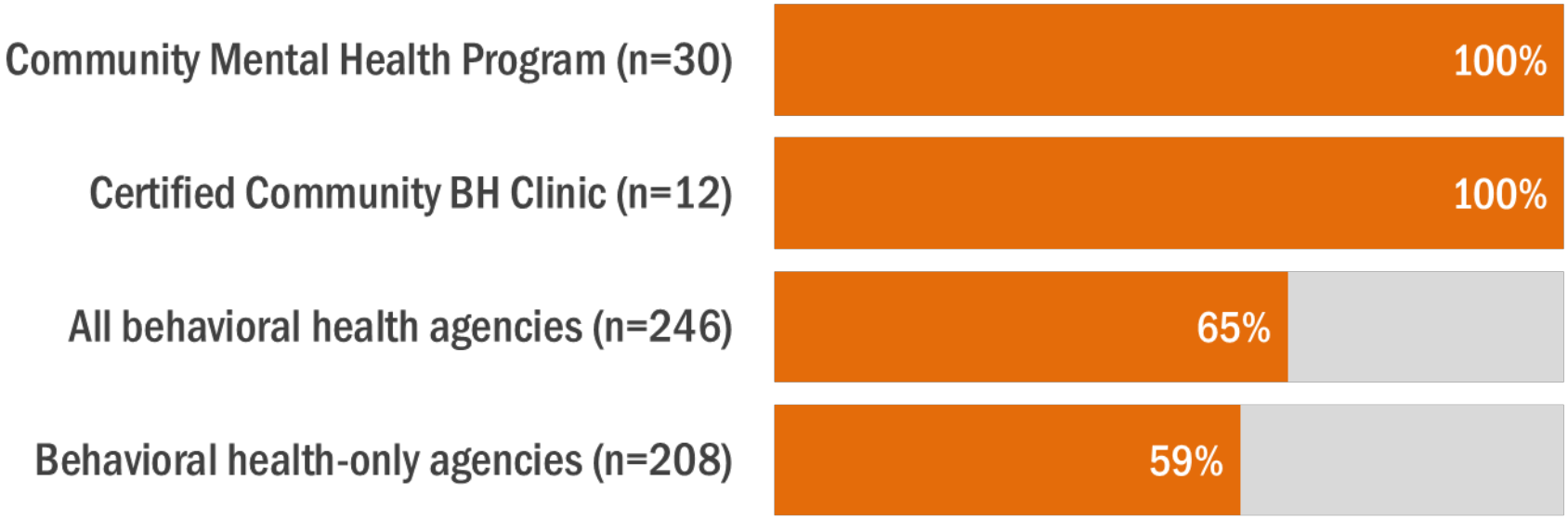


OREGON EHR ADOPTION IS VERY HIGH OVERALL, BUT DIGITAL DIVIDES EXIST.

	NUMBER OF DIFFERENT EHR VENDORS	TOP EHR VENDORS	EHR VENDORS THAT OFFER 2015 CEHRT PRODUCT
Hospitals (n=60)	10	Epic, 71% CPSI, 7%	90%
Patient-Centered Primary Care Homes (n=623)	26	Epic, 52% Centricity, 10%	85%
Behavioral health-only agencies (n=208)	49	Credible, 10% Qualifacts, 9% Netsmart, 8% 46 others, 74%	47%

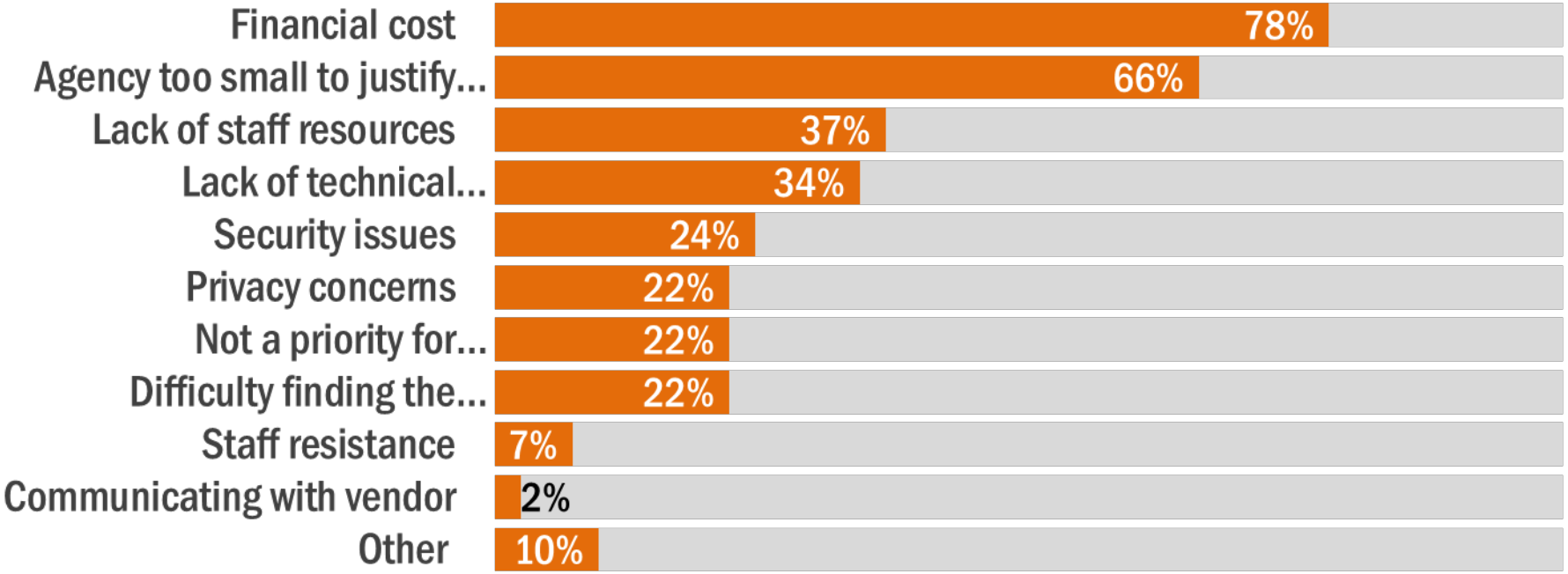
TWO-THIRDS OF BEHAVIORAL HEALTH AGENCIES HAVE

All Community Mental Health Programs (CMHPs) and Certified Community Behavioral Health Clinics (CCBHCs) are using an EHR.



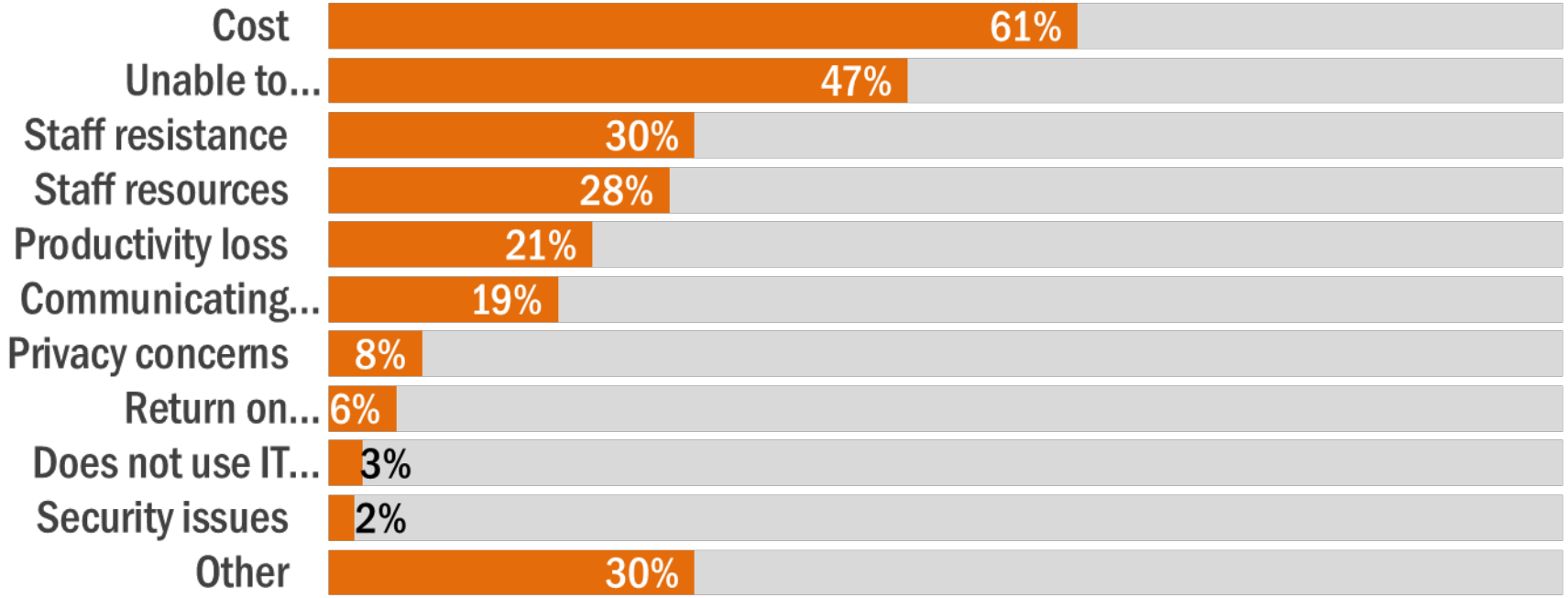
BARRIERS TO EHR ADOPTION IN BEHAVIORAL HEALTH

Cost and agency size are the two greatest barriers to adopting an EHR.

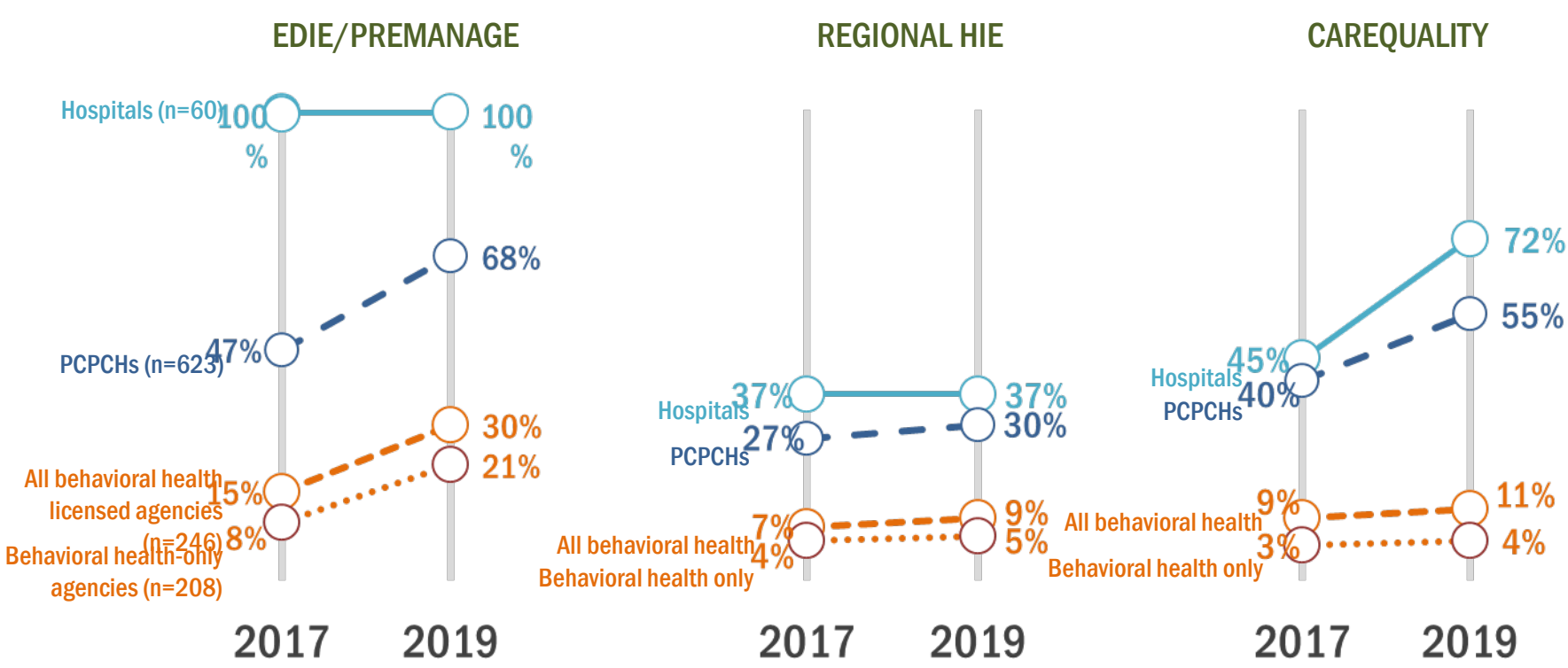


CHALLENGES OF EHR USE IN BEHAVIORAL HEALTH

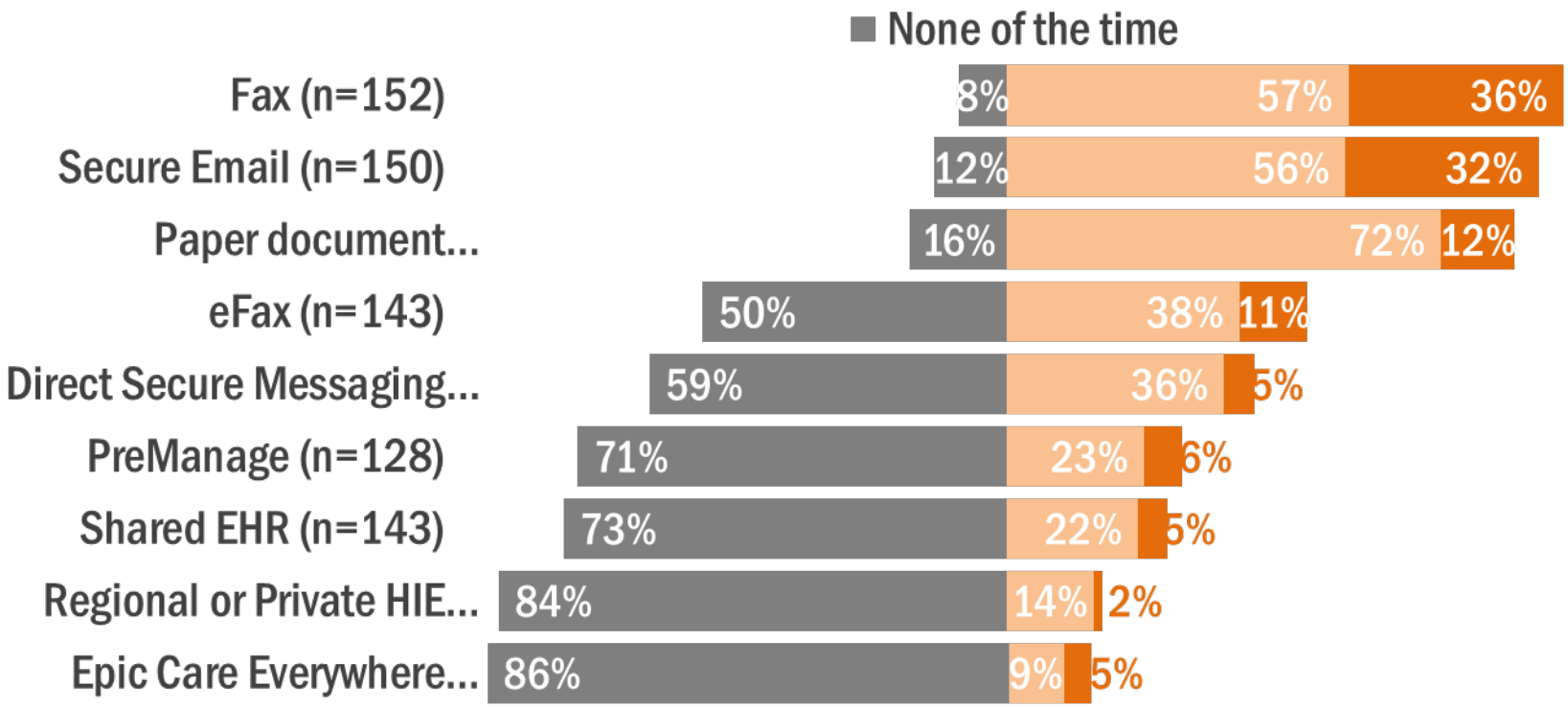
Cost and information exchange are the two greatest challenges to using an EHR.



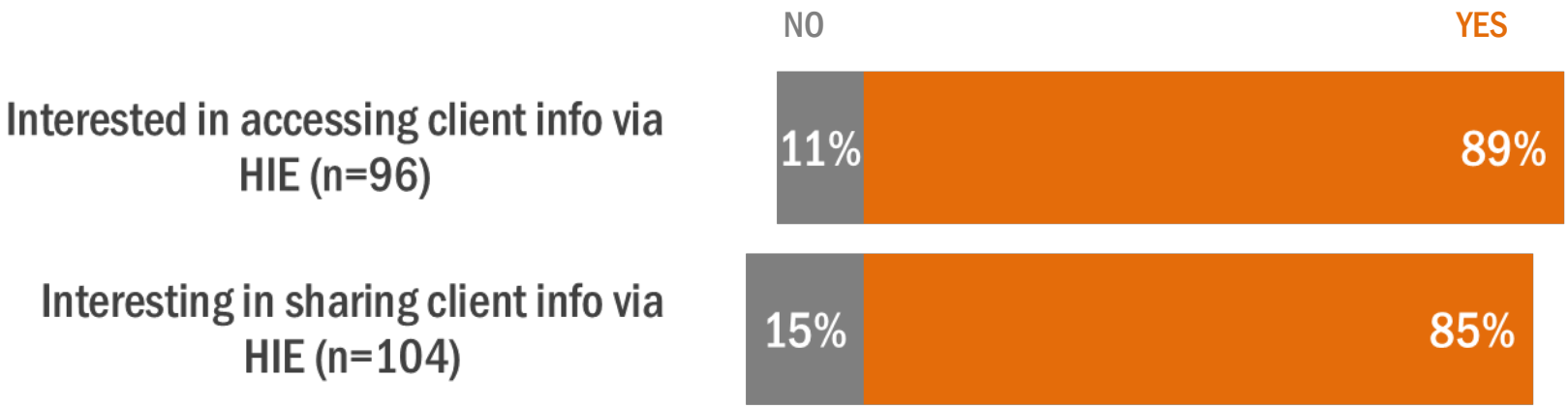
ADOPTION OF VARIOUS HIE TOOLS IS INCREASING IN



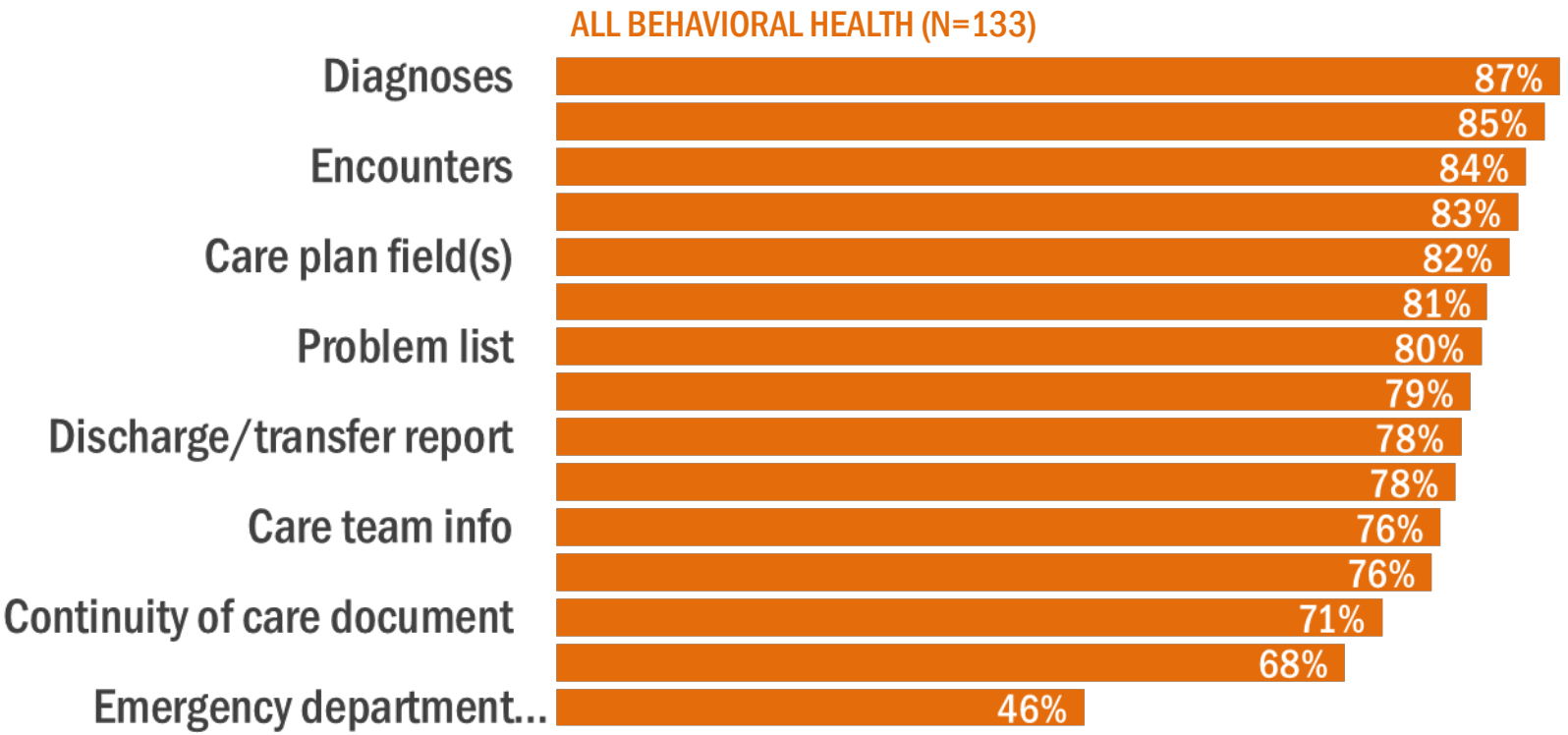
MOST BEHAVIORAL HEALTH CLINICAL INFORMATION IS STILL BEING SHARED VIA FAX, SECURE EMAIL ATTACHMENTS, AND PAPER DOCUMENTS.



BEHAVIORAL HEALTH AGENCIES ARE INTERESTED IN USING REGIONAL HEALTH INFORMATION EXCHANGE SERVICES

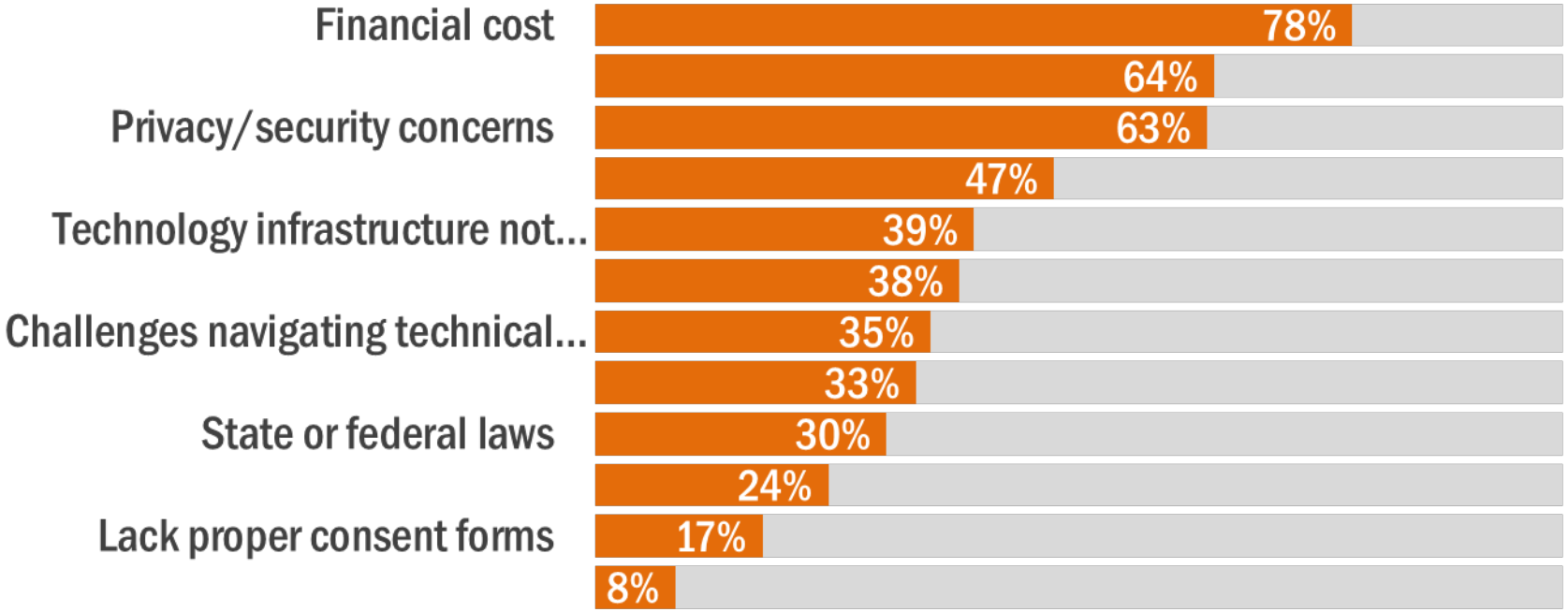


BEHAVIORAL HEALTH CAPTURES DATA ELECTRONICALLY



BARRIERS TO INFORMATION SHARING

Cost, technical resources, and privacy/security concerns are the greatest barriers to information sharing.



KEY HIE CONCEPT

- Federal regulations that provide special protection relating to substance use disorder treatment information (42 CFR Part 2) are challenging to interpret and result in reduced information sharing, even when such sharing is allowable under the regulation. **42 CFR Part 2 remains a barrier to behavioral health participation in HIE, due to perceptions as well as the regulation itself.**

LOOKING AHEAD FOR BEHAVIORAL HEALTH AGENCIES

Behavioral health organizations need EHRs that meet their unique information capture and management needs. These EHRs must be interoperable and support behavioral health reporting requirements, such as electronic metrics reporting.

Support needs identified in the Workgroup report:

- Navigating the EHR vendor landscape
- Shared learning opportunities
- EHR market analysis
- HIT education
- Financial incentives
- Support from larger, better resourced organizations

Discussion

Oregon Health Authority - Office of Health Information Technology

Behavioral Health EHR Adoption, Upgrades and Implementation

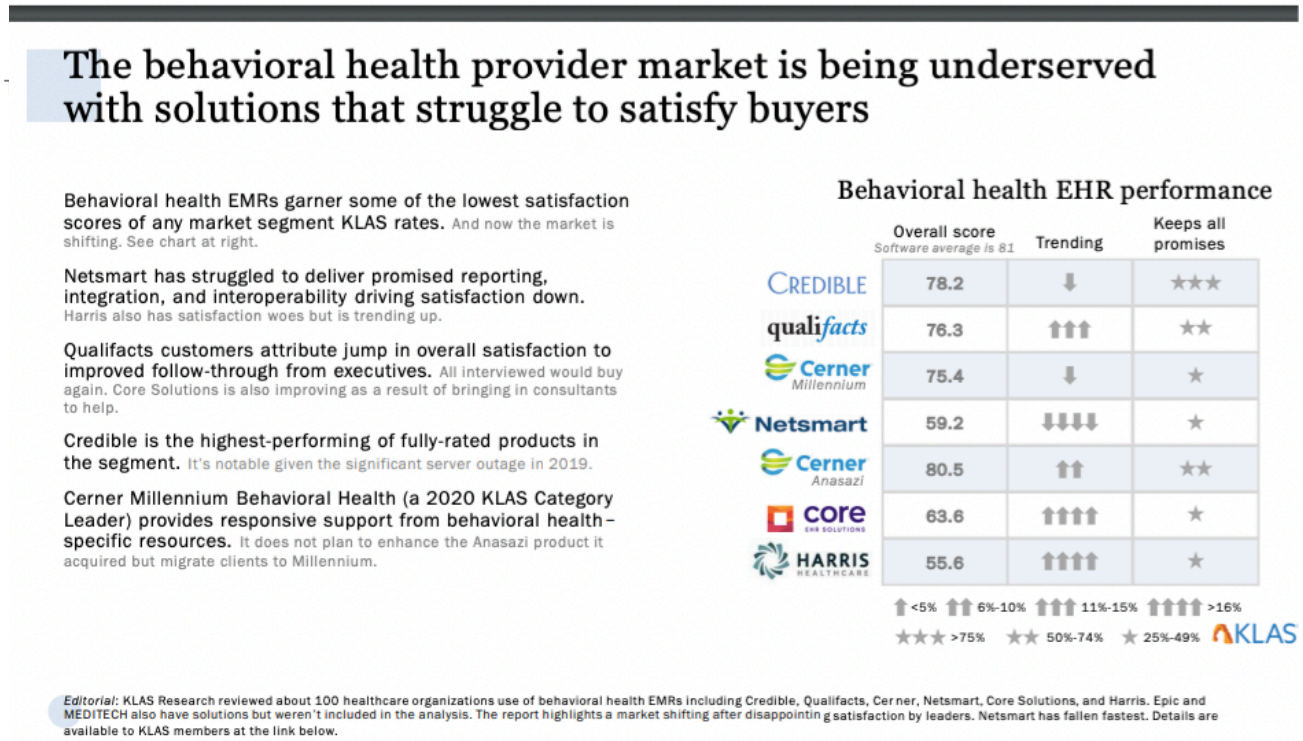
Amy Fellows, MPH
Fellows Health Connect, LLC/
Pivot Point Consulting

September 1, 2020

Top 5 Behavioral Health EHR products in OR

- Epic /OCHIN Epic
- Credible
- Nextgen
- Qualifacts
- Netsmart Evolv

Behavioral Health EHR Ratings
May 2020 – KLAS



The behavioral health provider market is being underserved with solutions that struggle to satisfy buyers

Behavioral health EMRs garner some of the lowest satisfaction scores of any market segment KLAS rates. And now the market is shifting. See chart at right.

Netsmart has struggled to deliver promised reporting, integration, and interoperability driving satisfaction down. Harris also has satisfaction woes but is trending up.

Qualifacts customers attribute jump in overall satisfaction to improved follow-through from executives. All interviewed would buy again. Core Solutions is also improving as a result of bringing in consultants to help.

Credible is the highest-performing of fully-rated products in the segment. It's notable given the significant server outage in 2019.

Cerner Millennium Behavioral Health (a 2020 KLAS Category Leader) provides responsive support from behavioral health–specific resources. It does not plan to enhance the Anasazi product it acquired but migrate clients to Millennium.

Behavioral health EHR performance

	Overall score *Software average is 81*	Trending	Keeps all promises
CREDIBLE	78.2	⬇	★★★
qualifacts	76.3	⬆⬆⬆	★★
Cerner Millennium	75.4	⬇	★
Netsmart	59.2	⬇⬇⬇⬇	★
Cerner Anasazi	80.5	⬆⬆	★★
core EHR SOLUTIONS	63.6	⬆⬆⬆⬆	★
HARRIS HEALTHCARE	55.6	⬆⬆⬆⬆	★

⬆ <5% ⬆⬆ 6%-10% ⬆⬆⬆ 11%-15% ⬆⬆⬆⬆ >16%

★★★ >75% ★★ 50%-74% ★ 25%-49% KLAS

Editorial: KLAS Research reviewed about 100 healthcare organizations use of behavioral health EMRs including Credible, Qualifacts, Cerner, Netsmart, Core Solutions, and Harris. Epic and MEDITECH also have solutions but weren't included in the analysis. The report highlights a market shifting after disappointing satisfaction by leaders. Netsmart has fallen fastest. Details are available to KLAS members at the link below.

EHR Cost Components

- EHR software license and maintenance
- Third Party software license, subscriptions & maintenance
- Interfaces
- EHR infrastructure and / hosting (if not hosted by vendor)
- Data conversion/archiving
- Legacy systems decommissioning
- Implementation resources
- Training resources
- Training space and materials
- Ongoing support

*produced by Pivot Point Consulting

Additional EHR Cost Considerations

- EHR customizations
  - One-time and ongoing
  - Impacts: EHR, interfaces and support
- Training time - staff backfill
- Data conversion
- Hardware and network upgrades
- Upgrades and/or adding modules over time
  - Upgrades may require additional resources/training
  - New modules may have additional fees/costs

*produced by Pivot Point Consulting

EHR Cost Model Recommendations

- Plan for one time (acquisition) and operating costs
  - 5 year horizon
  - Include inflation where appropriate
- Work with existing vendors
  - Legacy system decommissioning – contractual obligations
  - For 3rd party systems - may need new contracts, may be new fees
- Explore opportunities for subsidies or grants

*produced by Pivot Point Consulting

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*produced by Pivot Point Consulting

MOTS- State reporting

- Does the system connect to MOTS in an integrated way? (or will you have to manually upload data)
- How smooth is the workflow to link the patient to MOTS (if they are doing an assessment only?).
- SUD portion of MOTS based on CFR 42

SAMHSA 42 CFR Part 2 Revised Rule

- The revised rule does not alter the basic framework
  - continues to prohibit law enforcement's use of SUD patient records in criminal prosecutions against patients, absent a court order.
  - continues to restrict the disclosure of SUD treatment records without patient consent, other than as statutorily authorized in the context of a bona fide medical emergency; or for the purpose of scientific research, audit, or program evaluation; or based on an appropriate court order.
- The revisions were made to facilitate coordination of care in response to the opioid epidemic while maintaining confidentiality
- HHS Revised Rule Fact Sheet:
  https://www.hhs.gov/about/news/2020/07/13/fact-sheet-samhsa-42-cfr-part-2-revised-rule.html

SAMHSA CFR 42 Part 2 Final Rule

- HHS Substance Abuse and Mental Health Services Administration (SAMHSA) released their revised CFR 42 Part 2 Final Rule on Monday
  - Press Release
  - Fact Sheet
  - Full Final Rule Text

- The Final Rule focuses on modernizing CFR 42 Part 2 to bring it in-line with other modernization alignment activities.

SAMHSA CFR 42 Part 2 Final Rule (cont.)

Key Provisions Include:

- Non-OTP (opioid treatment program) and non-central registry treating providers are now eligible to query a central registry, in order to determine whether their patients are already receiving opioid treatment through a member program.
- Declared emergencies resulting from natural disasters (e.g., hurricanes) that disrupt treatment facilities and services are considered a "bona fide medical emergency," for the purpose of disclosing SUD records without patient consent under Part 2;
- Disclosures for research under Part 2 are permitted by a HIPAA-covered entity or business associate to individuals and organizations who are neither HIPAA covered entities, nor subject to the Common Rule (re: Research on Human Subjects);

SAMHSA 42 CFR Part 2 Revised Rule

Provision	What Changed?	Why Was This Changed?
Applicability and Re-Disclosure	Treatment records created by non-Part 2 providers based on their own patient encounter(s) are explicitly not covered by Part 2, unless any SUD records previously received from a Part 2 program are incorporated into such records. Segmentation or holding a part of any Part 2 patient record previously received can be used to ensure that new records created by non-Part 2 providers will not become subject to Part 2.	To facilitate coordination of care activities by non-part-2 providers.
Disposition of Records	When an SUD patient sends an incidental message to the personal device of an employee of a Part 2 program, the employee will be able to fulfill the Part 2 requirement for "sanitizing" the device by deleting that message.	To ensure that the personal devices of employees will not need to be confiscated or destroyed, in order to sanitize in compliance with Part 2.
Consent Requirements	An SUD patient may consent to disclosure of the patient's Part 2 treatment records to an entity (e.g., the Social Security Administration), without naming a specific person as the recipient for the disclosure.	To allow patients to apply for benefits and resources more easily, for example, when using online applications that do not identify a specific person as the recipient for a disclosure of Part 2 records.
Disclosures Permitted w/ Written Consent	Disclosures for the purpose of "payment and health care operations" are permitted with written consent, in connection with an illustrative list of 18 activities that constitute payment and health care operations now specified under the regulatory provision.	In order to resolve lingering confusion under Part 2 about what activities count as "payment and health care operations," the list of examples has been moved into the regulation text from the preamble, and expanded to include care coordination and case management activities.

Source: HHS

SAMHSA 42 CFR Part 2 Revised Rule

Disclosures to Central Registries and PDMPs	Non-OTP (opioid treatment program) and non-central registry treating providers are now eligible to query a central registry, in order to determine whether their patients are already receiving opioid treatment through a member program. OTPs are permitted to enroll in a state prescription drug monitoring program (PDMP), and permitted to report data into the PDMP when prescribing or dispensing medications on Schedules II to V, consistent with applicable state law.	To prevent duplicative enrollments in SUD care, duplicative prescriptions for SUD treatment, and adverse drug events related to SUD treatment.
Medical Emergencies	Declared emergencies resulting from natural disasters (e.g., hurricanes) that disrupt treatment facilities and services are considered a "bona fide medical emergency," for the purpose of disclosing SUD records without patient consent under Part 2.	To ensure clinically appropriate communications and access to SUD care, in the context of declared emergencies resulting from natural disasters.
Research	Disclosures for research under Part 2 are permitted by a HIPAA-covered entity or business associate to individuals and organizations who are neither HIPAA covered entities, nor subject to the Common Rule (re: Research on Human Subjects).	To facilitate appropriate disclosures for research, by streamlining overlapping requirements under Part 2, the HIPAA Privacy Rule and the Common Rule.
Audit and Evaluation	Clarifies specific situations that fall within the scope of permissible disclosures for audits and/or program evaluation purposes.	To resolve current ambiguity under Part 2 about what activities are covered by the audit and evaluation provision.
Undercover Agents and Informants	Court-ordered placement of an undercover agent or informant within a Part 2 program is extended to a period of 12 months, and courts are authorized to further extend the period of placement through a new court order.	To address law enforcement concerns that the current policy is overly restrictive to some ongoing investigations of Part 2 programs.

Source: HHS

OpenNotes and Behavioral Health

- **Providing a tool for behavior change**
- Patients may find that a balanced discussion facilitated by open therapy notes helps with anxieties they otherwise hold alone. In addition, health professionals in the OpenNotes study found that when some patients read medical notes about sensitive subjects, including substance abuse, they were more motivated to confront these challenges and address difficult changes in behavior.
- OpenNotes Mental Health Toolkit
  - https://www.opennotes.org/tools-resources/for-health-care-providers/mental-health/
  - Dobscha VA JAMA article (VA has had OpenNotes since 2010 including mental health records) https://pubmed.ncbi.nlm.nih.gov/26380876/

OpenNotes and Behavioral Health video clip

Telehealth

- COVID has been a game changer with telehealth visits now being covered by insurers
  - Many products have emerged:
    -zoom integration
    -doxy
    -Amwell
    -pexip
    -klara
    -avizia
    -snapMD
    -Mend VIP
    -OnCall Health
    -VSee
    -CarePaths
    -Genoa
    -TheraNest (private practice therapist product with telehealth and billing, scheduling components)
    -FaceTime (for Iphone/Apple users)
    -Web Ex and Zoom stand alone (limiting length of free meetings now)

Telehealth

Breakout Telehealth and EHR Integration

- **Pros/Cons of some of the telehealth platforms (phone, video, etc.) and using EHR to support your telehealth.** Questions: Which platforms are you finding that are the easiest to use? How did you set up the platforms for staff and clients to use them? Are you able to provide services by phone? If you're on EPIC, are you using their embedded Zoom feature?
- **Support for clients** Questions: What are you doing if a client is not able to use a video platform or doesn't have a phone? What if a client is not in a private space?
- **Support for staff** Questions: How are you supporting your staff if they are having difficulties navigating virtual platforms or experiencing technological challenges while working remotely?
- **Ethical and informed consent considerations** Questions: How are you obtaining informed consent? What are you sharing with clients about telehealth informed consent specifically?

Real Stories and Lessons Learned with EHR Adoption/Upgrade

Amber Clegg, Deschutes County Health Services

Collaboration is Key

- Create, update, and manage system with a team approach (clinicians, EHR admin, supervisors, billing staff, etc.)
- Continue to have ongoing multi-disciplinary meetings after implementation phase is over
- Conduct EHR trainings in partners (pair clinical/EHR admin staff together)
- Communicate with other users of the same EHR program around the state
  - Find mentors/partners
  - Share workflows, tips/tricks
  - Increased power in advocacy with your EHR Vendor if you combine efforts
  - May reduce costs

Super Users Are Invaluable

- Strongly encouraged at all levels - Supervisors/managers should be part of the group
- Find those willing/excited to learn more about the technical aspects and build on their strengths
- BUT be careful about overloading direct service staff with supporting others – may need to set boundaries
- Rob Devens with LCSNW will talk more about this topic later on

Be Part of the Process

- Offer to be on workgroups, pilot changes, or help test workflows for your EHR Vendor

- Be persistent – at times the EHR Vendor will say no to a change the first time.
  - Continue to educate about OAR's/fidelity needs
  - System/Staff changes may have occurred

- Leverage OHA – utilize your OHA contacts to help support increased regulatory requirements in your EHR system.
  - Provide specific audit findings

Supporting Your Clinical Work/Documentation

- Auto reminders – where possible, still a work in progress with EPIC

- Caseload reports – does it include things you don't need? And what is it missing?
  - Signature due dates
  - Level of Care
  - # of sessions

- Templates – adding in smartphrases, get from/share with others

Pros/Cons of an Integrated EHR model

Pros

- Increases communication/collaboration (ER, medical clinics)
- Shared language
- Improves integrated care approach
- Decreases risk and liability (SI/HI/Rx's)

Cons

- Medical system does not always align with behavioral health system – documentation processes/Dx's are different
- Very slow to adopt BH focused modules
- SUD information - we've had to create a workaround to protect information (42cfr, part 2)
- Shared parts of the chart can cause errors/changing of information that affects the other (Dx's)

Legacy/Epic/Kerr Connect Partnership

September, 2020

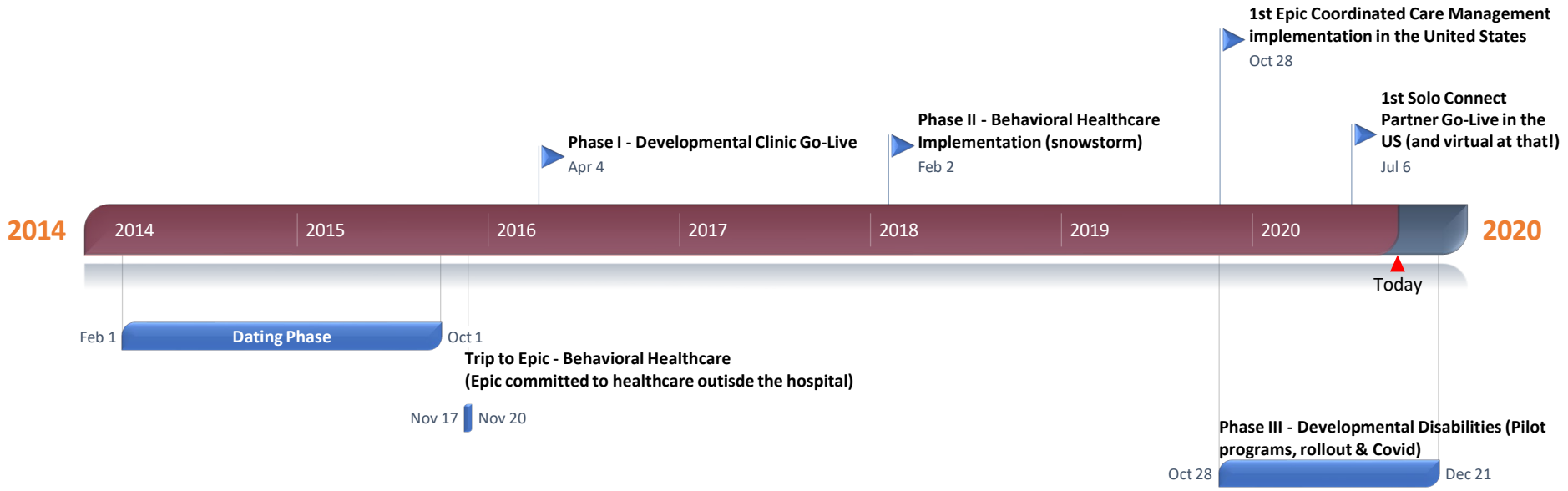
ALBERTINA KERR

Why Epic & Legacy

- Why Epic?
  - Client Centered - Integration between behavioral and physical health
- Why Legacy Connect?
  - Kerr & Legacy share common basic principles and beliefs
  - Legacy has inpatient and outpatient modules

ALBERTINA KERR

Brief History of Connect Partnership



ALBERTINA KERR

Key Connect Benefits

- Legacy is steadfast and true partner
- Epic “affordable” but not cheap
- Relationship with Epic
  - Development of Coordinated Care Management module
- No expensive hardware, network and security infrastructures
- Relatively small investment in Epic staff resources
- Mature oversight process helps reduce mistakes
- Legacy “best practices” guide implementation
- Legacy uses Epic, not just administers it

ALBERTINA KERR

Some Challenges

Legacy is a large hospital system -- committees, regulations & procedures

- Even small changes can take time

Kerr is different in many ways and has unique needs

- Kerr works with people, not patients
- Kerr clients can enroll in services for years or for life
- Therapists want to write assessments, not navigating complex medical systems
- Staff roles require unique system privileges
- Kerr's referrals are complex and do not fit neatly into Legacy's normal process
- Kerr's billing partners don't play by the same rules

Fortunately, Legacy has been flexible in accommodating our needs

ALBERTINA KERR

Staffing & Structure

- **Staffing**
- 1 FTE Certified Epic Analyst
- 1 FTE Certified Epic Trainer
- 1 FTE Certified Lean Process Improvement Analyst
- 15-20 Epic Super Users

- **Structure**
- Virtual support via Teams
- Analyst, Trainer and Super Users monitor Teams chat
- Epic enhancements prioritized by Kerr's Epic oversight committee
- Single point of contact with Legacy for changes
- Training in-house
- Participation in Legacy's Connect SUG

Strategies for Communication, Policymaking, and Support

Lutheran Community Services Northwest

Introducing LCSNW

- 9 Behavioral Health Offices across Oregon and Washington.
- Offices are unique and had been quite autonomous.
- Present EHR was first successful attempt at having one EHR for the entire Behavioral Health program of our Agency.

We needed a system for communication, policy making, and support

Communication and Policy Making

- **Clinical Oversight Teams** formed in each state with Representatives from each office.
  - If someone wants to make a change to the EHR or a change to policy, they have to take it through this team.
  - Decisions are made at that level and communicated out to the staff in each office.
  - Records are kept of all the decisions that are made.

Examples

- Policy: If it's not in the EHR it didn't happen
- Aligning the Service Plan Documentation
- A Workflow in One Office Infecting the Rest.

Principles We've Discovered

- Patience is a Virtue.
- Work for alignment, but only when alignment will actually make things better for everyone.
- When people see value in changing they will change.

Support

- **Super Users**
- Three levels of support:
  1) EHR Documentation
  2) Super Users
  3) EHR Admin staff.

Support

- **EHR Admin**
  - Support ticket system
    - Smartsheet
    - Distinct from our IT service desk
    - Only Super Users have access to the EHR Support Desk
    - Encourages staff to go through their super user.
  - Staff continually try to come directly to the EHR Admins

MOTS

- **MOTS Reps** in each local office
  - Creating MOTS reports and sending them out is centralized
  - Error reports come back to central person
  - Divide errors between offices.
    - Google sheets
  - MOTS reps are given access to the error reports and are expected to fix any errors before the next report is run

Still Have Long Way to go

- **It is a continuing process**

Things to Consider During an EHR Sales Demo

Andrew Yoder, South Lane Mental Health

Questions to explore during the product/sales presentation

- What is the vendor's implementation plan for a new customer?
  - How much time is allotted for implementation prior to go-live?
  - What kind of implementation team will exist on the vendor's side?
  - Is there a clear project management plan for implementation that can be viewed by you prior to sale?
- What is the vendor's plan for post launch support?
  - Who is primarily responsible for initial staff training?
  - Ask for a demonstration of the vendor's support management system
  - Will staff from the vendor be physically on-site during launch and for how long?

Questions to explore during the product/sales presentation

- What options does the vendor offer for managing and importing client data and prior clinical records?
  - It is important to know this up front because if the bulk of the responsibility for importing old data rests with your organization, this can potentially be a time-consuming or costly task
- Identify your organization's must-have data and reporting needs prior to sale.
  - It is perfectly acceptable to press the vendor to adequately demonstrate the system's capacity to generate the data and reports you know you need.
  - How familiar is the vendor with MOTS?

Questions to explore during the product/sales presentation

- Clarify how much control your organization will have over the system you are considering
  - How much control with you have over the design and implementation of clinical documents and other forms?
  - How much ability will you have to create custom reports in real-time?
  - What will system administration look like in the system?
- Clarify what types of training resources and documentation will be available to you as a customer
  - Is the vendor free or guarded with access to manuals and other technical information about the system?
  - Is there a community site where other customers share resources and information?

READ: Centering equity in data collection

MARJORIE MCGEE, PHD

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OREGON HEALTH AUTHORITY

SEPTEMBER 1, 2020

What is REALD? Why REALD?

(Race, ethnicity, language and disability)

House Bill (HB) 2134 passed seven year ago (2013)

- Originated from the **communities most impacted by health inequities**
  - Asian Pacific American Network of Oregon & Oregon Health Equity Alliance

HB 2134 required DHS and OHA to develop **data collection standards** in all programs that collect, record or report demographic data.

Data collection standards codified in 2014

- Extensive rulemaking advisory process
- OARs 943-070-0000 through 943-070-0070
- Based on local, state, and national best practices

Why REALD?

REALD ***provides consistency*** in data collection across OHA and DHS

With REALD data, together we can:

- Use information to improve client services and reduce inequities in testing as well as treatment
- Determine what groups are most impacted by Covid-19, for example.
- Address identified inequities through policy and legislative efforts
- Reallocate resources and funds needed to effectively address these inequities
- Design culturally appropriate and accessible interventions

As we review the REALD questions and categories, please:

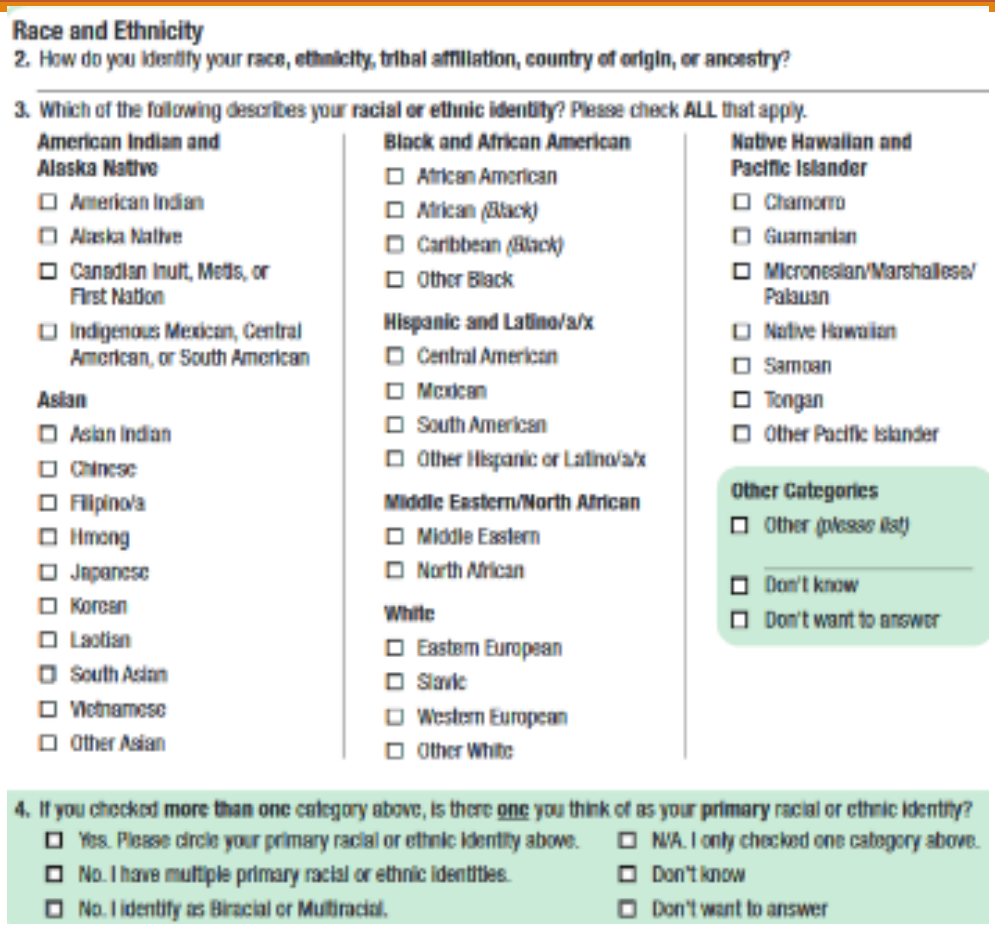
Notice the ‘buts’ that come up – is it about equity for those most impacted? Is it inwardly focused or outwardly focused?

Reflect on what this means in terms of changing values, norms and systems….

As yourself - What’s the impact on equity if we do/don’t do xyz….?

Three race/ethnicity questions:

- Open-ended question
- Question with 34 categories
- Primary Race question



Race and Ethnicity

2. How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry?**

3. Which of the following describes your **racial or ethnic identity**? Please check **ALL** that apply.

American Indian and Alaska Native
- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

Asian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Black and African American
- ☐ African American
- ☐ African *(Black)*
- ☐ Caribbean *(Black)*
- ☐ Other Black

Hispanic and Latino/a/x
- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Other Hispanic or Latino/a/x

Middle Eastern/North African
- ☐ Middle Eastern
- ☐ North African

White
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

Native Hawaiian and Pacific Islander
- ☐ Chamorro
- ☐ Guamanian
- ☐ Micronesian/Marshallese/ Palauan
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

Other Categories
- ☐ Other *(please list)*
- ☐ Don't know
- ☐ Don't want to answer

4. If you checked **more than one** category above, is there **one** you think of as your **primary** racial or ethnic identity?
- ☐ Yes. Please circle your primary racial or ethnic identity above.
- ☐ No. I have multiple primary racial or ethnic identities.
- ☐ No. I identify as Biracial or Multiracial.
- ☐ N/A. I only checked one category above.
- ☐ Don't know
- ☐ Don't want to answer

Five Language questions including alternate format question for written materials (Q1 on template)

Language

5. In what **language** do you want us to:

Speak with you _____

Write to you _____

Please skip to question 8 if the person is under age 5

6. How well do you speak English?

- ☐ Very Well
- ☐ Well
- ☐ Not Well
- ☐ Not at all
- ☐ Don't know
- ☐ Don't want to answer

7a. Do you need an **interpreter** for us to communicate with you?

- ☐ Yes
- ☐ Don't know
- ☐ No
- ☐ Don't want to answer

7b. If yes, what kind of interpreter do you need ***(pick all that apply)***:

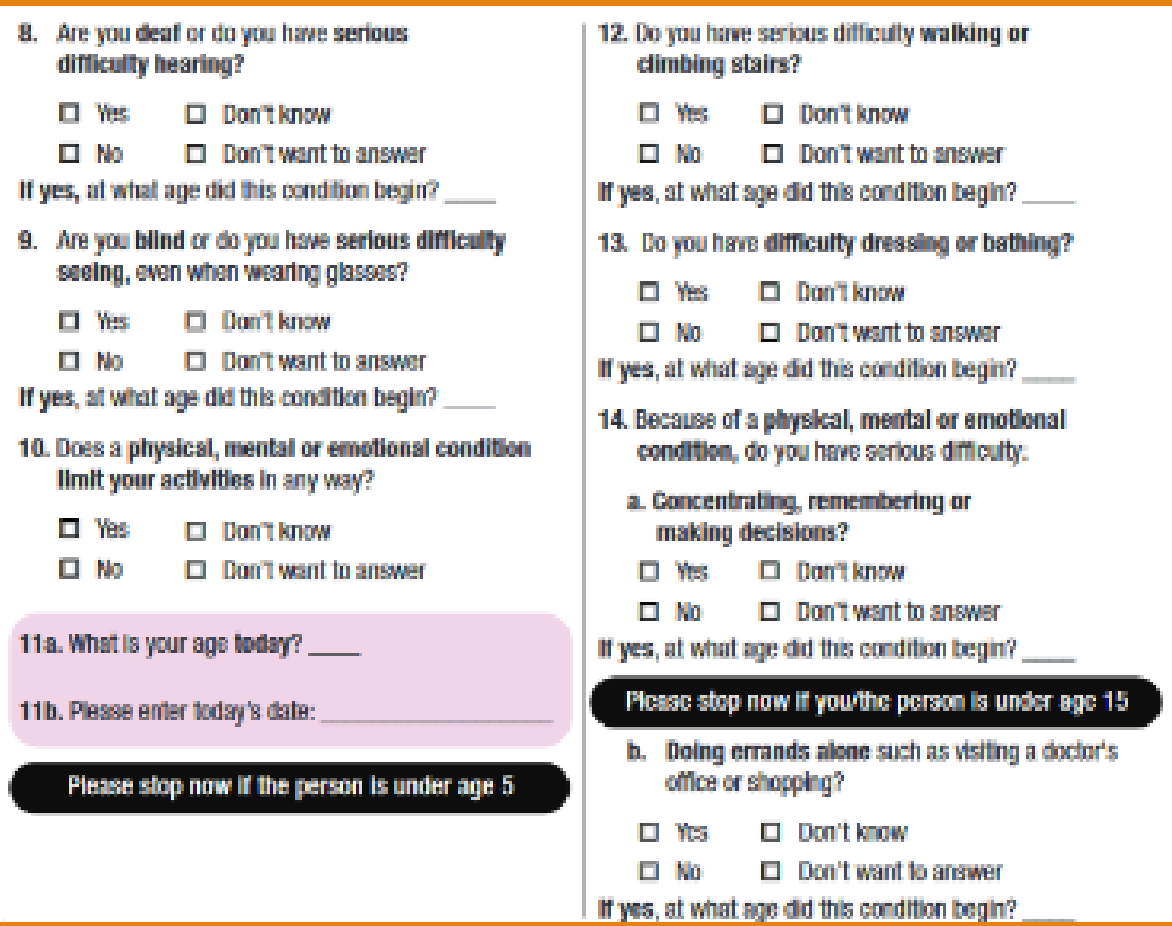
- ☐ Spoken language interpreter ***(please list)***:

  _____
- ☐ American Sign Language
- ☐ Deaf Interpreter for DeafBlind and Deaf with additional barriers
- ☐ Contact sign language (PSE)
- ☐ Other ***(please list)***: _____

Seven questions

- 4 major domains
  - Hearing
  - Vision
  - Cognitive
  - Mobility
- Self-Care
- Independent living
- Activity limitations

Age acquired question asked if 'yes'



8. Are you **deaf** or do you have **serious difficulty hearing?**

☐ Yes ☐ Don't know
☐ No ☐ Don't want to answer

If yes, at what age did this condition begin? ____

9. Are you **blind** or do you have **serious difficulty seeing,** even when wearing glasses?

☐ Yes ☐ Don't know
☐ No ☐ Don't want to answer

If yes, at what age did this condition begin? ____

10. Does a **physical, mental or emotional condition limit your activities** in any way?

☐ Yes ☐ Don't know
☐ No ☐ Don't want to answer

11a. What is your age **today?** ____

11b. Please enter today's date: _____

Please stop now if the person is under age 5

12. Do you have serious difficulty **walking or climbing stairs?**

☐ Yes ☐ Don't know
☐ No ☐ Don't want to answer

If yes, at what age did this condition begin? ____

13. Do you have **difficulty dressing or bathing?**

☐ Yes ☐ Don't know
☐ No ☐ Don't want to answer

If yes, at what age did this condition begin? ____

14. Because of a **physical, mental or emotional condition,** do you have serious difficulty:

a. **Concentrating, remembering or making decisions?**

☐ Yes ☐ Don't know
☐ No ☐ Don't want to answer

If yes, at what age did this condition begin? ____

Please stop now if you/the person is under age 15

b. **Doing errands alone** such as visiting a doctor's office or shopping?

☐ Yes ☐ Don't know
☐ No ☐ Don't want to answer

If yes, at what age did this condition begin? ____

OHA REALD Resources

OHA OEI REALD **Website**: https://www.oregon.gov/oha/OEI/Pages/REALD.aspx

REALD Templates in 20 languages– English version for clients/patients

- REALD Response Matrix (Guide for asking the REALD questions)
- REALD Implementation Guide

- **Other Data Resources**
- REALD and CDC Race and Ethnicity Cross-Map (Code Set Version 1.0)
- REALD to HRSA Cross-Walk Excel File

HB 2134 & REALD Rules

- REALD Demographic Data Collection Standards
- House Bill 2134

Service-based settings		
Generic (0074 series)	Parent/guardians filling out for a child with language needs of adult captured (0074b series)	Parent/guardians filling out for a child (0074c series)
English	English	English
Spanish	Spanish	Spanish
Arabic	Arabic	Arabic
Burmese	Burmese	Burmese
Cambodian	Cambodian	Cambodian
Chinese - Simplified	Chinese - Simplified	Chinese - Simplified

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REALD Response Matrix

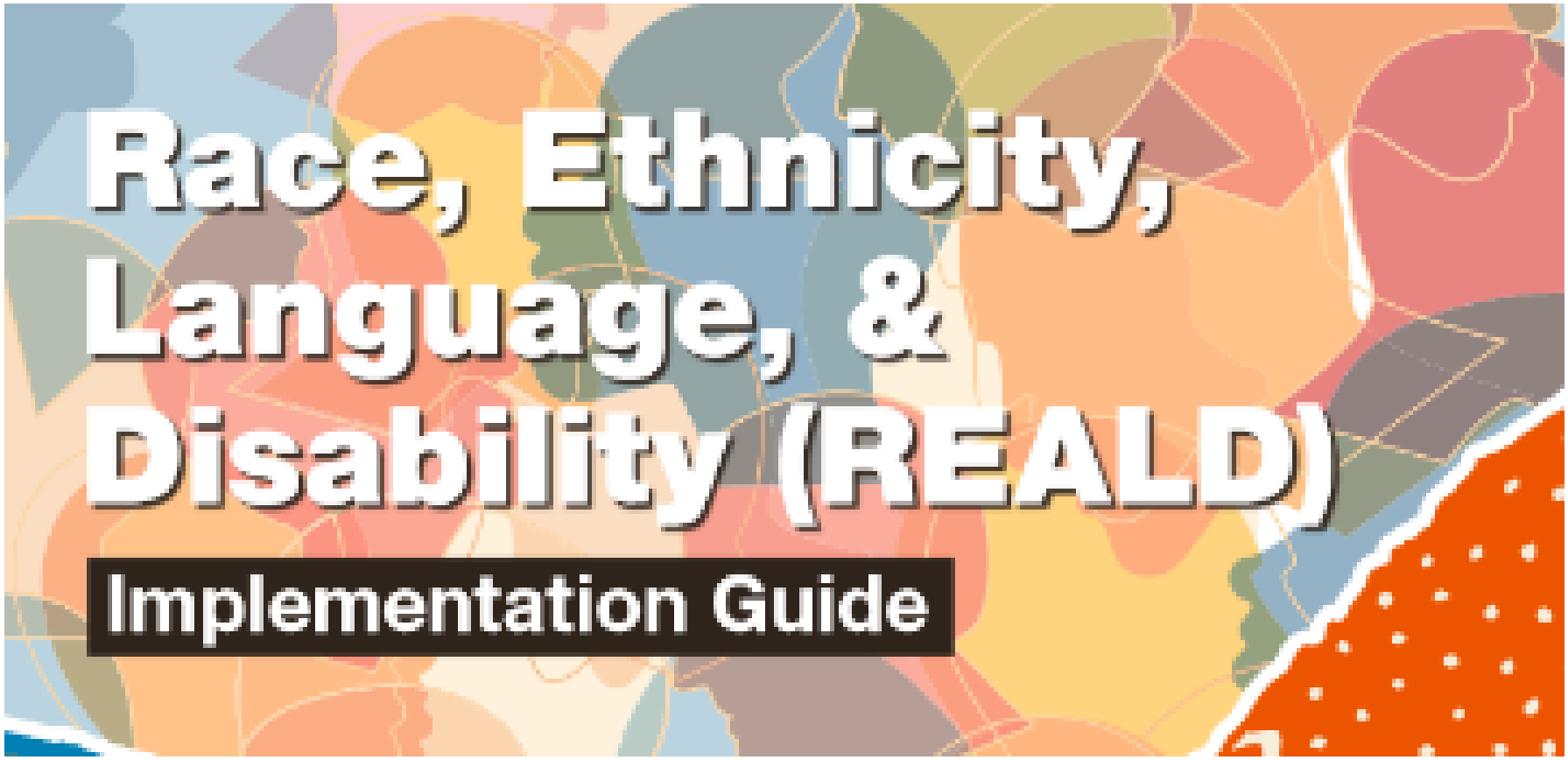
"We ask everyone about their race, ethnicity, disability, preferred language and interpreter needs. We do so to ensure that everyone receives the highest quality of care. Therefore, we ask about your race, ethnicity, language and disability."

(Recommended messaging for health care settings).

Guidelines for answers to questions from participants:

- Use common sense.
- Allow people to respond and use as much of their own descriptions as possible.
- Respect their descriptions (or choices if you provide categories).
- Avoid words that may be considered confrontational.
- If a person does not want to answer these questions, move on.

https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le7721c.pdf



OHA OEI REALD Website: https://www.oregon.gov/oha/OEI/Pages/REALD.aspx

Example - How REALD is being used during the pandemic

- Multnomah County Health Department
  - **Culturally Specific Response:** Oregon Pacific Islander Emergency COVID-19 Response
  - **Reallocation of resources**: Highly impacted but smaller communities increased access to resources
  - **Ensure language access**: Language diversity in Latinx community (indigenous languages) and White community (need for Russian and Slavic speakers) –informs contact tracer hiring

HB 4212 – REALD & COVID test referrals

HB4212 contained 11 sections:

- Local Government and Special Government Body and Public Meeting Operations
- Garnishment Modifications
- Judicial Proceeding Extensions and Electronic Appearances
- Emergency Shelters
- Low Income Utility Bill Assistance
- Notarial Acts
- Isolation Shelter Liability Limits
- Enterprise Zone Termination Extensions
- Individual Development Account Modifications
- Oregon OSHA Infectious Disease Standards
- **Race and Ethnicity Data Collection and Reporting During COVID-19 Pandemic**

HB4212, -30 amendment adopted

- Required OHA to ***adopt rules*** for collection and reporting of REALD data by a healthcare provider when ***ordering a COVID-19 test***
- Required a healthcare provider report the data in accordance with rules adopted under ORS 433.004
- Establishes a ***phased approach*** for REALD data collection and reporting, beginning 10/1/2020
- Requires, to the extent possible, data collection and reporting not duplicative
- States data subject to federal and state privacy laws
- Enforcement authority effective 12/31/2021

Reflections revisited:

How do we center equity in our processes so that we have equity in our outcomes?

What would have to happen in your organization / clinic so that there is buy-in and support for REALD?

- Workflow concerns – is this about staff or about the patients?
- How do address those concerns? Streamline processes so that it works?

EHR systems – Using existing HIT standards for race, ethnicity and language to bolster REALD

How can REALD be another vital tool in your toolbox?

Thank you for joining us today!

- Short follow-up survey to be sent out
- Next Behavioral Health Learning Collaborative 9/21/20 (registration info. in chat box)
- Contact: Jessi Wilson Jessica.L.Wilson@dhsoha.state.or.us

Oregon Health Authority