Best Practices for Implementing an EHR in Behavioral Healthcare

Part II
Plans

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Introduction

Little has been written about Electronic Health Record (EHR) implementations in behavioral healthcare agencies. EHR systems are one of the most expensive purchases and high impact projects in which a BH provider will engage. There has been almost no research on behavioral health adoption of EHR's. In the most recent study[1], done in 2006, the National Council found that just under 8% of community behavioral health providers had implemented an EHR system. Most agree that this number has steadily been growing. The number of EHR systems specifically for behavioral health providers has increased. Unfortunately, without proper planning, many of these implementation projects fail.

The main risk factors for EHR failure include:

- Poor communication;
- Lack of involvement in the planning by key stake holders; and
- Lack of sustained top level support and poor implementation planning.

Key factors in successful EHR implementations include:

- Establishing well formed goals and setting benchmarks;
- Excellent communication and project management; and
- A thorough work flow analysis and implementation plan.

This paper will report on twenty-three best practices. In the first installment (see http://www.solutionsinbh.com/solutions-blog/) we discussed goals. In this second installment of three, we will explore the role that various plans play in a successful implementation.

Data Gathering Methods

The following sources were used in creating this report:

Interviews: In researching this paper the following were interviewed about their implementation processes, best practices, and difficulties they encountered: EHR vendors, agency implementation project managers, senior staff at managed care companies, CIO/MIS directors and staff, and end users.

Literature Search: An extensive literature search was conducted and the contents of over 25 selected articles are incorporated into this report.

Personal Experience: Throughout the report I have interjected ideas based on my experience implementing several EHR systems over the past 14 years.

Limitations

Articles on EHR and PM implementations are plentiful. Unfortunately, very few of these are specific to behavioral healthcare and the majority come from medical EHR implementations. Although the majority of the issues are the same or similar, the research is limited due to a lack of written resources specific to behavioral healthcare.

Notes on Language

Behavioral Health is used to mean both mental health and substance abuse providers. The terms "agency" and "BH provider" are used interchangeably.

The terms EHR – Electronic Health Record, and EMR – Electronic Medical Record, are used interchangeably in this report.

The terms client, patient, consumer and person served are used interchangeably in this report.

The term CIO refers to the Chief Information Officer, a position found more and more among BH providers.

Chapter 2 - Plan

"It is not enough to just do your best or work hard. You must know what to work on."
~W. Edwards Deming

Utilize Staff Roles in Planning and Implementing:

Thinking of the implementation in terms of the roles of the staff that will utilize the system can streamline the implementation[3,9]. Role identification can be utilized in work flow analysis, training design and implementation as well as EHR set up for both user access and security. Be sure to include the following roles:

- Clinicians, including interns
- Non-master's level direct care staff
- Front Desk staff
- Supervisors - clinical and administrative
- Program Managers
- Directors
- Outside Auditors
- Funders
- State Licensing Agencies
- Accreditation representatives
- MDT staff
- Quality Assurance/ Quality Management staff
- Compliance staff
- MIS

It is important to evaluate differences within roles. Not all MIS staff need nor should have the same access to the EHR; an outpatient clinician and an emergency service clinician have different needs. Be sure to differentiate these needs within a role and document them.

Conduct a Thorough Work Flow Analysis:

Almost every project manager, research paper, white paper and article written on EHR implementation stresses the importance of the thorough work flow analysis[4,5,9,10,15]. Each process needs to be carefully examined, at the source, and mapped out on paper. One potential barrier to a successful implementation is not getting to the end user; but rather relying on a department manager or supervisor to be the definitive source of information on work flow. It is imperative to talk to the staff actually doing the work to find out how it is done, rather than how it should or is thought to be done. Another key is to talk to the staff at each program and location. It should not be assumed that one outpatient process will be replicated throughout a behavioral healthcare provider system. Case managers who work with adults may have a very different

It is imperative to talk to the staff actually doing the work to find out how it is done, rather than how it should or is thought to be done.

experience compared to those who work with children[13]. Several sources recommend letting the site(s) come to consensus on work flow to establish better buy in and ultimately, higher and faster adoption rates.

One source[3] recommends using your established goals to inform your work flow processes. For example, if “consumer-focused practice” is a goal, how does the work flow reflect this goal? How can the work flow be improved to be more "consumer-focused? Another author warns that work flows have to align with clinical processes[5]. For examples, in one implementation, a progress note for a psychiatrist was developed using the Massachusetts Standardized Documentation Project[16] forms as a template. When reviewing several MD notes, it was discovered that only one text block was being used out of many in the EHR progress note. One psychiatrist and several of his residents were copying and pasting a Word Template into the EHR form because they preferred the order of the headings. Clearly the work flow did not take their practice into account.

It is also important to remember the environment in which the work flow is occurring[5]. Mobile Crisis clinicians may at first insist on “net book” computers because they are constantly on the move and the net book provides a light and highly portable solution. However, mobile crisis also requires completing many forms in a short period of time, and the small screen, low power and keyboard size can hinder this process.

Question to ask:

- How well is the current process working?
- How will this process be represented in the EHR?
- What are the areas for improvement within the process? Do they involve the EHR?
- What can we do in the EHR to make the end user's experience better, more productive and/or meet the overall goals of the implementation[13] and our agency?
- What are the requirements we are trying to meet?

As part of the work flow analysis it is important to ask about processes that may operate below the radar. For example, are there small databases, index cards, lists or spreadsheets staff use to assist them in their jobs? These should be incorporated into the work flow. In addition, the Compliance Officer should be involved in the work flow analysis to be certain your agency is meeting all of the payer, regulator requirements, and applicable accreditation requirements.

One component of a thorough work flow analysis is the discovery of areas that are in need of improvement. These can take many forms; an identified training need, an inefficient practice, skipped required processes, etc. Your goal is to discover the current work flow and improve the process by implementing an EHR, not just replicating the current process. You may be very happy with your intake process and the EHR you are considering does it very differently. Do not discount the product before finding out the thought process behind the vendor's decision to create a different work flow for intake. Maybe there are options you can set;

maybe they have discovered something better.

Create an Implementation Plan:

All large projects such as an EHR implementation require a well written and thorough implementation plan[6,15]. The plan should address the best practices specifically mentioned in this report as well as:

- Realistic and flexible timetables.
- "[Assign] resources, schedules, task dependencies and milestones that will be used to manage the total implementation effort."[6]

In her article, The Six Keys to Successful EHR Implementation[3], Adele Allison creates an excellent list of the vital components of a project plan that should be consulted.

The project plan should be treated as a living document; the blue prints of the implementation, with frequent updates, notes, task assignments[3], and when necessary, adjustments. Be sure to include:

- Steering Committee membership and design
  - Lines of communication with the project manager and vendor
  - Project Meetings, status reports, project plan updates, vendor coordination, consumer communications updates, common files area
- Feedback mechanism; e.g. focus groups
  - Engagement strategy and time line
- Roles and responsibilities of the project manager, Implementation Team, EHR help desk function, and IT Director.
- Time lines
  - Transition to EHR from paper
- Key decision points to include:
  - Deployment strategy: functional vs. geographical
  - Server vs. hosted solution
  - Technology acquisition
  - Scanning/paper records strategy
  - Consumer Portal
  - Staff Portal
  - Help desk/ user support design
  - Data Migration
  - Work Flow Analysis design
  - Data transfer strategy
  - Interoperability goals (e.g. labs)

The project plan should be treated as a living document; the blue prints of the implementation

    - Dual system management during implementation
    - Billing transition plan including testing
- Issue tracking
- E-prescribing
- Clinical Documentation Plan (See next section)
- Reporting
    - Management
    - Finance
    - Clinical
- Meeting Meaningful Use Criteria
- Interoperability
    - G/L
    - HR
    - Outside systems
- Training Plan
    - Scope (basic computer skills, etc)
    - Methods
        - Webinar based
    - Design
    - Sample records
    - New staff entering your system
- Backup Procedures
- Contingency planning
- Policy and Procedures
- Compliance
- Measurable Outcomes/Measurements of Success
    - Progress note adherence
- Testing Plan
- Site or LOC readiness /implementation assessment tool
- Risk analysis and mitigation strategies
- Spend a lot of time on configuring the software – thinking about how to build out the drop-down tables. The time spent will make the go live phase smoother[11].
- Establish centralized feedback so that issues are communicated to one person or office that tracks the issues and uses their resolution to create a support knowledge base[4].
- Creating a series of test clients
- The implementation plan should include a plan for scanning old chart contents. Based on experience, a few guidelines:
    - If you can't read the writing on the paper version, it won't be any more legible scanned!

    - Clinicians do not typically look at notes more than 3-4 sessions back.
    - Prescribers will need to have more old notes scanned; typically one year's worth.
    - Just because an outside agency sent you a 150 page report, does not mean you need or want to scan the entire thing.
    - Scanning always takes longer than people think.
- Include a plan for "maintenance" scanning; new material coming into the system including insurance cards, outside reports, correspondence and parts of the record that require consumer signature.
- Carefully plan out how to transfer medication data. This is a huge time saver for the prescribers. If you are already using an e-prescribing tool, look into the possibility of a data transfer, possibly using an HL7 formatted file. If the prescriptions are hand written, have a nurse load the prescriptions into the system so the prescriber just needs to refill and make other minor adjustments when a consumer is seen for the first time using the EHR system. It is important that a person with medical training, such as a nurse, does the data entry. Nurses are familiar with the medication names, doses, and know when to ask questions. Remember to verify and document drug allergies; a major component of meaningful use adherence.
- Post-implementation and annual reviews are key. No matter how good of a job you do in implementing the new EHR, not every efficiency will be recognized. Patches, new releases coming out, enhancements being developed, new staff being hired, and programs expanding will all require changes to the EHR. It is important to review the use of your system over time and include it in the implementation plan from the start tor maximum efficiency and return on investment.

One CIO highly recommended having the implementation plan on-line allowing all members of the implementation team to contribute to it on an on-going basis, and having a visible plan on a white board in the meeting room[13]. The visible plan should include deadlines and task assignments. This will help to keep tasks and deadlines prominent and hold team members accountable. Consider using a project management software.

Clinical Documentation Plan:

For your direct care staff, the core of the EHR are the medical record forms. Each vendor will have forms available to you right out of the box. Most vendors allow you to create your own, or pay to have the vendor create customized forms (be sure to explore this detail during contract negotiations). Whether you decide to use the vendor' forms, make your own or adhere to a standard set of forms, you can use the clinical forms decision process as an opportunity to enhance your clinical forms. Here are several key elements:

- **Match and support the clinical philosophy of your agency**. Over the past few years I have noticed an increase in number of agencies that are adopting best practices and using established practice guidelines. If your agency or a department

within your agency has a "Solution Focused" approach to treatment, and your paperwork is based on a psychodynamic model, the forms will not support the work being done. Make the forms match the work.

- **Meeting medical necessity.** Meeting, or proving, medical necessity, must be one of the results of your clinical documentation process. One key to meeting medical necessity is the linkage between the major form components; assessments, treatment plans and notes. Fortunately, there are sophisticated resources available for implementation teams to consult. The following are standardized documentation projects that have medical necessity at their core:
  - Solutions for Ohio's Quality Improvement and Compliance (SOQIC) - Use your web browser to search for information.
  - The Massachusetts Standardized Documentation Project (MSDP) - http://www.abhmass.org/site/msdp.html.
  - The New York State Clinical Records Initiative (NYSCRI) - http://www.omh.state.ny.us/omhweb/nyscri/.
- **Meet Meaningful Use Criteria.** Simply put, be sure the vendor you are working with is fully certified.
- **Meet Payer Requirements** - Based on your contracts, state regulations and requirements, there may be certain forms you must use. These will need to be added to the system if they do not already exist.

Getting a group of providers within a single clinic of your organization to agree on a set of clinical forms is a monumental task. Getting your entire organization to agree can be daunting. The implementation of an EHR can be provide the needed impetus for making changes to your clinical documentation. One method is to collect all of the forms used throughout your organization and begin to standardized as much as possible.

Carefully Plan Training and Support:

Training will be one of the most important parts of the implementation plan and should not be left to the end of the implementation to plan. Key elements of a training plan include:

- Just in time training[9]. Timing of the training is key. Train too early and staff will not remember the material. It is ideal for staff to be trained and immediately be able to use what they have learned.
- Too often trainers assume basic computing skills have already been mastered. Don't assume, ask and test (staff often over estimate their own abilities). There are several on-line tools for testing typing speed and accuracy, and a survey can be used for self reported skill assessment.
- Expect Uneven skills. Assessing staff's basic computer skills will

Don't assume basic computer skills are mastered - ask!

allow you to design classes tailored to each individual's needs. More advanced users will learn to log on, move around the system rapidly and want to get to the “meat” of the system as soon as possible. Users unfamiliar with an EHR will need more time to master basic skills. Try to have staff learn using the type of computer they currently have and know. Having to adjust to a new keyboard and/or mouse while learning a new EHR will slow down learning and adoption.

- Use adult multi-sensory learning techniques. Trainers in Behavioral Healthcare often assume that clinicians, social workers, residential counselor and the like are auditory learners and use mainly didactic presentation styles. In fact, only approximately 40% will have an auditory lead learning system; 40% will be visual, and 20% kinesthetic. The use of slides, lectures, and hands on practice is vital when teaching to all learning styles.
- Use a Test system. Knowing you are not going to “blow up the system” by trying something will free the new user to experiment and learn faster. Have a demo or test system available to practice on. It is better for clinical and case management staff for the demo system to have realistic case examples that closely resemble the consumers with whom your agency works. Take the time to build these test clients' files.
- Use Learning Labs. Working alone at your desk on a test or live system works for some, but a more efficient use of resources is to create a training or learning lab. A lab allows you to make expert staff available and creates a “learning environment.” Another advantage of a training lab is that staff are less likely to get interrupted or distracted in a lab[10].
- Go Slow. Another common error is to pile too much information on new users and hope they will be able to go back and get what they missed from the handouts. They won't. Administer tests to be sure people have the skills at one level before moving onto the next.
- Be prepared for clinical questions. Ideally your training staff should be clinicians or familiar with your clinical procedures and requirements. Using the EHR technologically accounts for some, but no where near all of the skills needed to successfully use an EHR. Knowing how to write a goal statement, that meets medical necessity criteria, is just as important, if not more, than knowing where in the EHR to record these data.

Be prepared for clinical and procedural questions during training.

- Be prepared for clinical procedure questions. How often do we need to do MDT? Update the client's treatment plan? Are we allowed to cut and paste from a previous document the staff person wrote? Another staff person wrote? A myriad of clinical process questions will be raised during training. If you are not certain, differ to the clinical director.
- Offer as many training opportunities as possible. Staff are worried about productivity as much as management. Work with staff to schedule training times that fit with their schedules and allow them to use what they are learning.
- Be clear what is a change due to technology and what is a change in work flow.

Adding a new field because it is a requirement, but not one that was required before, is different than requiring the data because the EHR vendor included a data field on the form.[9]

- When needed, provide one to one support. In general, group training sessions are more economical. There are times, however, when a valuable staff person needs one on one training; this is worth the investment. The staff person will be more at ease, be able to get focused training and will not slow down other staff in their learning.
- Plan for new staff early. Training plans often only focus on existing staff. A plan for bringing new staff on board should be developed early and tested.

Laying The Ground Work For Concurrent Documentation:

With a well planned EHR system, the use of concurrent documentation – completing documents while meeting with a consumer, can have huge positive effects on an organization. Potential benefits include:

- **Better documentation**. Direct Care staff that are disciplined will take the ten minutes between sessions in outpatient settings to write up their sessions notes. Others will complete the notes at the end of the day, or week. As more time elapses, the quality of the note will diminish. Concurrent documentation captures the salient elements of a session, during the session.
- **More time**. Direct care staff rarely have free time and most can barely keep up with record keeping requirements. Concurrent documentation, particularly of progress notes, can free up time between sessions and at the end of the day to complete the more complex documentation requirements.

Concurrent documentation can free up time for staff

- **Increased focus on goals and being consumer orientated.** Doing concurrent documentation forces the staff person to include the consumer in the documentation process. This can increase the focus on goals and measuring progress.
- **Cleaner claims and lower take back risk due to missing documentation.** Having the note completed at the time of the session will decrease the number of lost claims and the risk of take backs for non-existent documentation.
- **Increased staff morale**. Having the feeling of always being behind in work, never being able to say you have competed a task can have a negative impact on staff morale. Concurrent documentation can increase job satisfaction.

Very few staff will have any experience with concurrent documentation. There have been some studies published on the topic within the behavioral healthcare field. Several key aspects to implementing concurrent documentation include:

- The EHR system should allow staff to start a document and save it as a draft to be finished later. Although some of the work is done with the consumer in the room, it is

not always possible to complete the document prior to having to see the next consumer.

- Start with the documents, based on the work flow, that are the easiest to complete with the client in the room. A major goal here is to maintain rapport with the consumer. If the staff person is not comfortable with the EHR, and/or not proficient at typing, rapport will suffer. Dr. Bill Schmelter, considered an expert on concurrent documentation, suggests starting with the progress note. Staff can complete this toward the end of the session[17] so the entire session is not spent typing. Dr. Schmelter believes that most therapists do a "wrap up" toward the end of a session and doing concurrent documentation in a progress note is a natural extension of this.
- Focus effort on the processes that will give you the most return. Most agencies start with their prescribers; their most expensive staff and typically the scarcest resource. One CIO[13] recommended working closely with the prescribers to decide what equipment, office set up and work flow will best support concurrent documentation.
- When designing the system and work flow, having resources immediately available on the computer will greatly support concurrent documentation. Any information not readily available in help buttons or menus will cause the user to either stop listening or stop talking to the consumer in order to find the information, or skip doing that section of the note concurrently.
- One of the biggest challenges in implementing concurrent documentation is not the consumer or staff person but rather the forms themselves. Too many forms do not support sound clinical documentation that adheres to medical necessity, compliance standards, and logical work flow design. If the underlying tool you are using is flawed, the results, even if done concurrently, will not meet standards.

Linda Rosenberg from the National Council writes that, "The ideal preparation for transition to concurrent documentation involves:

1. Staff training (preferably on-site but can be done via web-ex).

2. Recruitment of volunteers to conduct a pilot (in the present context the pilot staff would be perfect candidates).

3. Implementation of a concurrent documentation pilot that includes minimal collection of data to demonstrate the reduction in documentation to direct service ration as well as to provide support for ongoing improvement in the process."[18]

Another good resource are the writings of Dr. Bill Schmelter[19] and the Midwestern Colorado Mental Health Center[20].

Carefully Plan Transferring Data:

The task of transferring data from older legacy systems to the new EHR can be a serious source of frustration and mistakes.

- Carefully decide what you really need. "Because we have tracked this for years" is not a valid reason for moving large volumes of data from one system to another. Carefully evaluate the data you will be transferring, and verify the need by going to the source document and seeing the requirement. For example, the claim, "it's a compliance requirement!" should be verified by looking at the regulations.
- Test and validate the data before and after you migrate. Most vendors will have you test the data once it is migrated into the new system. It is also important to validate the data before you migrate it.
  - When was the last time you truly asked consumers to update their contact information?
  - Is the insurance/billing information you have on clients up to date?
  - Are 60% of your clients listed as "unidentified" for race, ethnicity, primary language? Now is the time to complete this data.
- Are all of the providers you are moving into the new system current employees?

Carefully evaluate the data you plan to transfer before and after the conversion.

One author believes that the lack of information in the EHR at the start is one of the primary reasons for loss of productivity[11]. One suggestion he makes is to allow users to have both the paper and electronic chart available for existing clients during the transition. Each agency will need to decide if it prints the electronic notes for existing consumers and maintain dual records for a time. My experience is that this is necessary until everyone (clinical staff) that comes into contact with the client is up on the electronic record, at a minimum using it in view only mode. In an integrated system, the order of implementing different programs needs to be well thought out as it can impact how soon one department can stop printing and filing in the paper chart.

Create Contingency Plans:

As part of the implementation plan, it is prudent to include provisions for interruptions, delays, and unexpected problems in the EHR implementation. Similar to a disaster recovery plan, contingency planning during the EHR implementation will save time in the event of a delay[15].

Questions to address:

- How will we record notes in the event the system is not available?
- How will we access scheduled appointments?
- How will we prescribe refills/new medications?

The following systems and operations should have contingency plans in place as they are being implemented and beyond implementation:

Billing - Running parallel billing systems is very challenging at best and impossible at worst. However, at the point of switching over, it may be prudent to load the claims into both the old and new systems, plan and bill from the new, but be prepared to submit from the old. Another approach is to create a mechanism for loading the claims data into the old system for billing, in the event a problem occurs and a billing deadline is rapidly approaching. Having a paper form available (or at a minimum a hard copy master of a service activity log - SAL) for staff to complete as services are being rendered is important.

Front Desk Functions: It is vital to know who is coming in when and where for services, being able to collect co-pays and set next appointments and remind staff when treatment plans are due. Running parallel systems for these functions should be considered until there is confidence that the new system is working properly. If switching over systems or down time is anticipated, printing schedules or moving them to a searchable spread sheet is recommended.

Medications: It is highly recommended that your agency maintain a supply of compliant paper prescription pads. If switching over systems or down time is anticipated, printing current medication lists or creating a searchable spreadsheet is recommended.

Back up power plans. Whether in implementation or live, power outages can cause huge issues. Having internet connectivity available via tethered cell phones or other means (such as the Virgin myfi) and a system for accessing these tools in the needed location is recommend. Mission critical locations should consider power backup systems.

Back up systems: Test your back up system before a major change. Many agencies have back ups in place, but few actually try to restore information from a back up tape. I known of several agencies that discovered their back-up tapes were useless only after it was too late. Consider switching to a cloud based back up system.

A good guide on contingency planning has been compiled by Cheryl Fahrenholz[21] that is worth reading.

Take Away Points:

- A thorough work flow analysis is essential - take the time to do it right.
- Create a thorough Implementation Plan.
- Create a Clinical Documentation Plan.
- Carefully plan training and data transfer.
- Create a contingency plan.
- Back up your data!

End Notes

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Input Welcome

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