Making the Switch:

How and Why Your Behavioral Health Practice Should Transition to Electronic Health Records

Detailed records are an integral part of every healthcare practice. Accurate patient information, readily available to doctors, nurses, and staff members helps make treatment more effective and practice operations more efficient.

Medical recordkeeping has traditionally been done with paper forms and charts, a practice that has carried over into the digital era for many practitioners. However, electronic health records offer many benefits over paper records. They can help your practice improve quality of care, decrease the amount of time spent creating and locating charts, and increase revenue through more accurate billing. By leveraging digitization and cloud based technologies to organize and share information, EHRs can help your organization save money, save time, and improve patient outcomes.

Unique Challenges for Behavioral Health Practices

Behavioral health practices face a unique set of challenges that are not shared by other medical fields. Capturing the clinical narrative is critical for effective treatment of patients, accurate reimbursement, and risk management. Mental health professionals also use forms and assessments that are not used by other specialties. Choosing an EHR system that is specifically tailored to the needs of behavioral health practices can help amplify the benefits of implementing a digital records system.

This paper was created to serve as an introduction to EHRs for behavioral health practices. It will go over some of the major benefits of using electronic records, offer tips to help you avoid potential pitfalls when making the transition, and help you choose an EHR that's right for your practice.

EHRs Make Care More Effective

75% of providers report that EHRs allow them to deliver better patient care[1]. EHRs can significantly improve patient outcomes by providing a more organized, more streamlined way to record, access, and share information. This, in turn, lets clinicians diagnose, prescribe treatment, and care for patients more effectively.

Improve Accuracy

One study of the accuracy of paper records in eight Baltimore hospitals found discrepancies between 17% of charts and factsheets, as well as errors in coded diagnosis in 15% of charts.[2] Such discrepancies can lead to serious inaccuracies in reimbursements, mistakes in treatment, and lowered quality of care.

Above all else, computers and digital technology excel at organizing and analyzing information. Electronic records are usually more accurate, more legible, and less likely to be lost than their paper counterparts. Studies show that implementing electronic records can decrease inpatient medication errors by as much as 55% relative to physical records when used alone, and by as much as 83% when coupled with a clinical decision support system.[3] A clinical decision support system combines knowledge and data to present helpful information to clinicians as care is being delivered, enabling the clinician to make informed decisions and prevent adverse outcomes.

Share Records and Improve Collaboration

Another recent study of three large community mental health centers in Indiana found that electronic medical records provided medication documentation that was more complete and faster to retrieve than paper records across all centers and within each center. On average, electronic medical records were 40% more complete and 20% faster to retrieve.[4]

Paper files are subject to physical limitations that digital files are not. EHRs put more data into one place, making the right information easier to find when it's most important. Clinicians and staff can edit the files in separate physical locations, and instantly have access to the changes that others have made. This increases collaboration among practitioners, allowing the entire treatment team to quickly view assessments made by other practitioners, get opinions from colleagues, and work together to offer the best care. It also improves the patient's experience by reducing the number of times the same information must be provided to different parties.

Engage the Patient

Digital records aren't just easy to share with fellow staff and practitioners; they're also extremely easy to share with the patients themselves. Test results, clinician recommendations, and medical history information can be made available to patients securely through web portals. Patient education material and clinical summaries can be easily printed and given to the patient to take home. This helps increase a patient's commitment to their own health, and improves satisfaction with the quality of care.

EHRs Make Care More Efficient

In addition to improving patient care, EHRs can also save a practice time and money. By offering a more organized and automated system, an EHR can improve workflow, streamline billing, and minimize medical-legal risk.

EHRs Save Time

One of the most cited reasons for transitioning to EHRs is the ability to save time. 79% of providers report that with an EHR, their practice functions more efficiently.[5] Nurses using EHRs have seen their time doing paperwork reduced by as much as 45% over paper records.[6] EHRs improve organizational efficiency by combining an integrated scheduling system with charting and electronic billing. Appointments are linked directly to the patient's chart and the provider's documentation of the encounter automatically generates a list of codes for billing purposes. The EHR then submits and manages the claim electronically, within hours of treatment, rather than days. For clinicians, these efficiencies translate into more paid time spent seeing clients.

Efficiencies Gained From EHRs

Chart Management

- No more time spent hunting for charts or missing information
- Multiple staff members with appropriate access privileges can view and modify a patient's chart simultaneously. No one has to wait for a chart to become available.

Communication

- PHI can be accessed from outside the office, which is useful in emergencies.
- Practices can send and receive secure messages electronically and assign patient-related tasks to other staff members.

Many EHRs feature checkboxes, templates, and other time-saving features for entering information in a fraction of the time it would take with paper charts. These systems are able to store and automatically enter data so that patients and healthcare professionals don't have to repeatedly write in the same information. Although these template-based systems can be extremely useful for many healthcare

practices, they are less useful in behavioral health due to the importance of capturing the clinical narrative. That is why it's so important to choose an EHR, like ICANotes, that is specifically designed to address the needs of behavioral health. ICANotes features a button-driven narrative note generation tool that enables you to create full progress notes in just two to three minutes with minimal typing and no dictating.

EHRs Save Money and Reduce Risk

The right EHR can increase your practice's profitability through improved billing and less clinical-legal risk. As a behavioral health practitioner, you no longer get paid for what you do, you get paid for what you document. Payers are becoming increasingly stringent on their documentation requirements for services. Failure to provide the necessary information can delay claims, result in denied claims, or the payer can recoup payments during audits. EHR software makes it easier for clinicians to create notes that meet documentation standards. Notes written by hand are often under-documented, and therefore under-coded. With an EHR, reimbursement charges more correctly reflect the severity of the patient's condition, so the notes are coded correctly and reimbursement is higher.

Typical Behavioral Health Cost Savings

Heritage Behavioral Health saved $473,859 over three years, in the following areas: $211,000 for transcription and documentation; $146,000 for chart audit paybacks due to non-compliant documentation; and $117,000 for back-office staffing reductions.[7]

Behavioral health is an area with increasing risk exposure and is an area of high scrutiny from accrediting bodies as well. The right EHR can reduce your risk with the availability of prompts to ensure a thorough record is completed. For example, a simple EHR prompt can ensure that a clinician does not forget to ask a patient about suicidal ideas. Automatic alerts can save lives by preventing a dangerous combination of medications from being ordered. Legible notes and prescriptions also reduce the likelihood of errors. The quality of your documentation is your most important factor in minimizing your risk exposure.

EHRs Reduce Financial Penalties

Eligible professionals who have not demonstrated meaningful use of electronic health records will face a 1% penalty in their Medicare reimbursements in 2015. Penalties are due to increase by 1% each year until 2019, when they will plateau at 5%. For providers also not participating in Medicare's electronic prescribing program, the penalties start at 2% in 2015, also plateauing at 5% in 2019. In addition, all providers must continue to demonstrate meaningful use every year through 2019 to avoid penalties. A one-time demonstration is not sufficient.

In addition, eligible professionals who do not satisfactorily report data on quality measures for covered professional services will be subject to a penalty of 1.5% under PQRS beginning in 2015. For 2016 and subsequent years, the payment adjustment is 2%.

How to Effectively Make the Switch

We have already seen how EHRs can make behavioral health practices more efficient, more effective, and more profitable. Now we will examine how your practice can effectively transition to electronic records. Fortunately, adopting an EHR doesn't have to be challenging. This section will guide users through the necessary steps to ensure a successful transition.

Overcome Barriers to Successful EHR Adoption

There are several reasons a practice may struggle when implementing an EHR. Addressing these pitfalls early in your selection process will ensure your practice makes a smooth transition.

- **Financial Costs -** One of the most significant barriers to EHR adoption is cost. Although an EHR will almost certainly have a net positive financial impact on the practice over the long term, initial costs can be intimidating. One recent survey found that the initial average cost for an EHR was $44,000 per full time equivalent, with ongoing costs averaging $8,500 per full time equivalent.[8] Fortunately, ICANotes offers a much more affordable pricing model. If implementing ICANotes with out-of-the-box functionality, a full-time psychiatrist with one front office staff can anticipate spending $3625 annually, and a full-time therapist with one office staff $1866 annually.

- **Staff Resistance -** Clinician resistance was cited in one recent survey as the second most common reason for not adopting an EHR.[9] Although electronic records can help clinicians and staff work more efficiently once they are used to the system, the transition does involve a learning curve. To avoid this pitfall, it is essential to involve clinicians in the selection process. Forcing doctors to use a system built by software developers with no clinical experience is a recipe for disaster. The only way to get clinicians committed to using an electronic record system is to include their input every single step of the way.

- **Privacy and Compliance Concerns -** Many people, both inside and outside the health industry, are distrustful of computer systems that deal with sensitive health information. It's important to address these concerns head on, and ensure that the EHR you select uses HIPAA-compliant technology and processes to protect your digital data. In many ways, an electronic record is more secure than paper. Anyone can access a paper chart without using a password or leaving a trace.

Steps for a Successful Transition

1. **Identify Goals**
   Consult clinicians and staff to identify desired functionality. Include the entire organization in the decision-making process to ensure that everyone's needs are considered and to increase staff commitment to the transition.

2. **Assess Readiness**
   Determine whether you have the necessary IT infrastructure to support an EHR (computers, high-speed internet connection). Ensure your patient data is sufficiently organized to facilitate speedy digitization.

3. **Choose an EHR**
   Select an EHR capable of meeting your needs. Look for a specialty-specific EHR with an intuitive clinical workflow. For more information about choosing the right EHR, see the following section *Choosing the Right EHR*.

4. **Train Users**
   Without proper training the EHR transition can lead to inefficient workflow and staff dissatisfaction. Consult with the EHR vendor to create a systematic plan for instruction and schedule mock "go-live" sessions to ensure that the process goes as smoothly as possible.

5. **Implement the EHR Gradually**
   Develop a thorough plan for your migration and fully test the system before your go live date. You don't have to make a complete transition all at once. You may want to use a hybrid of paper and electronic records to help staff adjust to the new system. Start by importing demographic data for active patients only. Best practice is to upload a patient's initial assessment, most recent progress note, allergies, medication, and diagnoses. For appointments and billing, taper off your old system while transitioning to the EHR. Enter all new appointments and claims in the EHR, while closing out prior appointments and claims in your old system. There will be a brief period of overlap as you close out your aging balances.

6. **Assess and Improve**
   Once the transition has been made stay vigilant about optimizing the system. Assess what is working effectively and what isn't. Be sure to include input from all users and communicate your recommendations to your EHR vendor. Don't forget to conduct regular training sessions to ensure that staff are kept up to date on any software and process changes.

Choosing the Right EHR

Selecting the right EHR can be the most difficult part of the implementation process. It is important to choose an EHR that offers the functionality and service you need at a price you can afford.

Key Questions to Ask an EHR Vendor

Can I try the system before I purchase?
A vendor that believes in its product should offer a free trial period and no long-term contract. Take advantage of the trial to fully evaluate whether the program is a good fit for your practice.

What is the average time between purchasing the system and go live?
The ability to implement quickly and get your staff up and running is vital to ensuring a smooth transition for your practice. The EHR you choose should be easy to use with minimal training. Get a clear understanding of the vendor's implementation and training process and timeline.

How many live behavioral health sites are using your product?
You want to work with an EHR vendor that offers a mature product and a solid grasp of behavioral health. You also want to choose a vendor that will remain in business in the years to come. Look for a vendor with at least 10 years of experience and that is implementing at least 150-200 sites annually.

How will I be supported and trained on the system?
Even with a system that is easy to use, helpful and available customer service is important to a successful deployment. Look for vendors offering unlimited ongoing support and training from a live person.

How often do you upgrade your product?
There are a lot of legacy systems on the market today. You want to select a vendor that will be committed to adapting to evolving state and federal regulatory changes specific to behavioral health. The system should be updated frequently and the vendor should incorporate user suggestions into the product. Make sure the product design is controlled by a clinician with expertise in behavioral health.

Why Choose ICANotes?

ICANotes is the only comprehensive EHR designed by a clinical psychiatrist specifically for behavioral health clinicians like you. Whether you work in a private outpatient practice or a multidisciplinary inpatient setting, you will find ICANotes intuitive, clinically useful, revenue-enhancing, and affordable.

ICANotes is web-based, meaning that you can be up and running with a secure, hassle-free EHR solution in minutes without changing your existing processes and without a large capital investment. You can access and work on your patient records at any time from any computer or smart phone with an internet connection.

ICANotes is designed to work the way you think, and can be further customized by you to meet your clinical and documentation needs. With thousands of pre-formatted template buttons arranged in clinically logical ways, you can quickly create detailed and individualized clinical documentation in minutes with no typing required. This customizable point-and-click functionality will reduce the time you spend documenting patient care, eliminate transcription expenses, and help protect you from medical-legal liability.

ICANotes automatically determines the highest billable coding level your note supports so you can confidently bill at the maximum level of reimbursement. ICANotes is also ONC-certified and will capture all the data required for meaningful use and clinical quality measures so that you can avoid financial penalties.

ICANotes will not slow you down. Our interface is user friendly and simple to navigate. In just minutes, you will start charting, scheduling, e-prescribing, managing documents, messaging, reporting, and managing your practice. We provide unlimited free support and one-on-one training. ICANotes has everything you need, and our friendly, proactive support team will help you every step of the way.

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References:

[1] Improving Diagnostics and Patient Outcomes. HealthIT.gov. http://www.healthit.gov/providers-professionals/improved-diagnostics-patient-outcomes. Accessed February 2015.
[2] Fox KM, Reuland M, Hawkes WG, Hebel JR, Hudson J, Zimmerman SI, Kenzora J, Magaziner J. Accuracy of medical records. J Am Geriatr Soc. 1998 Jun;46(6):745-50. http://www.ncbi.nlm.nih.gov/pubmed/9625191. Accessed February 2015.
[3] Hoyt, Robert. Benefits of Switching to an Electronic Health Record. Practice Fusion. http://www.practicefusion.com/health-informatics-practical-guide-page-2/. Accessed February 2015.
[4] Tsai, Jack and Bond, Gary. A comparison of electronic records to paper records in mental health centers. http://dx.doi.org/10.1093/intqhc/mzm064 136-143 First published online: 13 December 2007. Accessed February 2015.
[5] http://www.healthit.gov/providers-professionals/medical-practice-efficiencies-cost-savings
[6] Pennic, Fred. 80 Mind Blowing EMR Statistics and Trends. HIT Consultant. October, 30, 2012. http://hitconsultant.net/2012/10/30/80-mind-blowing-emr-and-meaningful-use-statistics-trends/. Accessed February 2015.
[7] The ROI of EMR-EHR: Productivity Soars, Hospitals Save Time and, Yes, Money. HIMSS: 2006.
[8] Miller RH et al. The Value of Electronic Health Records In solo or small group practices Health Affairs 2005;24:1127-1137
[9] http://www.practicefusion.com/health-informatics-practical-guide/