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About this issue

Electronic Health Records for Behavioral Health Providers

This issue of *National Council News* brings together the experiences and challenges of behavioral health providers in implementing the Electronic Health Record. Articles from industry experts profile the status, the need, and the future of EHRs. Several National Council member organizations that have pioneered EHR implementation in behavioral health share lessons learned and outline the benefits they have realized.

As in all of healthcare, adoption of the EHR is no longer a choice but an imperative for behavioral health providers. The questions are when, why, and what works best. We hope this newsletter will be a resource in answering these questions. It is intended to supplement ongoing discussions and learning about the EHR through other National Council forums such as the member listserve, Meet Me Calls, and Annual Conference sessions.



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Go to www.nccbh.org to access this issue of *National Council News*, along with additional web-exclusive articles.

Each issue of *National Council News* provides in-depth perspectives and tools on a key issue in behavioral health. We would love to hear from our readers about whether this newsletter is helpful to you and about themes you would like to see covered in future issues. Please email your feedback and suggestions to MeenaD@nccbh.org.

Exploring the Power of New Technologies to Solve Old Problems

David Evans, Executive Director, Austin Travis County MHMR Center and Mike Morris, President, Anasazi Software, Inc.

Implementation of the Electronic Health Record in a community behavioral health organization presents unique challenges, far more so than any other development projects, grants, or service implementation. Integrating functions like authorization, progress notes, and billing can make any organization nervous. Further, the expectations of multiple funding agencies, enrollment in networks, the independent practice of medicine, performance and productivity demands, client rights and confidentiality, and contractual requirements, are all factors that add to the complexity of the EHR.

Leading the implementation of the EHR is perhaps the greatest challenge confronting even those CEOs who are skilled at change

management. The EHR ushers in cultural, organizational, procedural, management, and supervisory areas. And as Kotter reminds us in his book, "Leading Change," organizational culture is the last to change. It is a fundamental error in judgment to believe the culture must change before the EHR is embraced. Leadership must be out ahead with the mission-critical call to change and help the culture change as the value of the EHR to the organization becomes evident. New technical capacities are realized only when they are embedded in the way we do business, not when they are seen as additional processes.

In leading this massive change effort, what are some of the key challenges that management

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The Intersection of Corporate Compliance and the Electronic Health Record

Michael Lau, PhD, LCPC, Director of Corporate Compliance, North Central Behavioral Health Systems, Inc.

Recent federal audits have altered the accountability level of community mental health centers and considerably refined compliance, clinical culture, and individual clinical practices. Corporate compliance and information technology — traditionally unimportant and even divergent concepts in community behavioral healthcare — have come to play a significant role in the way an organization strategizes, develops, and manages service delivery. Today, the philosophy of clinical compliance and the mechanics of information technology have become so intertwined that it would be counterproductive for an organization

to develop one without focused attention on the other — community behavioral healthcare has reached a point where these two functional areas must continuously intersect.

At North Central Behavioral Health Systems, Inc., the intersection of corporate compliance and information technology began in earnest with the development and implementation of the Electronic Health Record. Having implemented not one, but two EHRs, we learned that in order to maximize the benefits of the technology, EHR implementation must be driven by a

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Electronic Health Records — the Promise and the Challenge

Jeannie Campbell, Executive Vice President, National Council for Community Behavioral Healthcare

Adoption of the Electronic Health Record is inevitable for every behavioral health provider. The questions are when, why, and how best to go about it.

WHEN — In 2004, President Bush issued an executive order requiring fully operational EHR adoption throughout the healthcare industry by 2014. He also established the Office of the National Health Information Technology Coordinator and charged it with developing a “health information technology infrastructure” that “reduces healthcare costs resulting from inefficiency, medical errors, inappropriate care and incomplete information.” In November 2006, the Medicaid Commission completed its second and final set of recommendations to Congress, recommending that EHRs, including compatibility among different healthcare providers, be required for all Medicaid beneficiaries by 2012. Congress will focus on healthcare information technology during its 2007 legislative session.

Today, EHR adoption is slow among healthcare providers in general — one study shows that only eight percent of community health centers are using full electronic medical record systems. A September 2006 National Council quick poll of community behavioral health providers across the country indicates that just under eight percent have implemented the EHR with clinical components fully functioning, while 32 percent have implemented the EHR with billing components in place. Another 11 percent of providers are in the process of installing an EHR. Lack of funding and the complex demands of multiple payer and reporting systems are the biggest barriers to EHR adoption in behavioral health.

WHY — EHR adoption is expected to reduce healthcare costs by up to 20 percent, significantly cutting back on the approximately 25 cents of every healthcare dollar that is now spent on record keeping and “administrivia” (according to James Kretz, MA, a senior survey statistician at SAMHSA’s Center for Mental Health Services).

The National Council quick poll revealed that 26 percent of behavioral health organizations with

functional EHRs realized improved quality assurance. Twenty two percent had been able to reduce billing errors and 17 percent realized improved clinical productivity with EHR implementation. Providers also point out that the EHR offers critical support to the service improvement process. The EHR promotes the application of protocols and guidelines, helps to maintain contact with individuals who move through a complex system and who are hospitalized in local or state hospitals, lose stable housing, or become entangled in the criminal justice system.

“The EHR holds the promise to reduce the enormous financial burden of paperwork and reporting duplication.”

Most of all, the EHR holds the promise to reduce the enormous financial burden of paperwork and reporting duplication. We know the problems of a paper-based system and certainly the substantial and cumulative economic impact.

A study of one community mental health center in California found a host of inefficiencies that could be easily overcome with adoption of an EHR

- 3,000 to 10,000 hours of care, with an annual value between \$360,000 and \$1,000,000, were going undocumented.
- 25,000 to 42,000 hours of clinician time, with an annual value of \$2.2 to \$3.7 million, were lost due to inefficiencies in the manual paperwork completion process.
- 13,000 to 20,000 hours of support staff time, with an annual value between \$500,000 and \$700,000, were spent on unnecessary medical records work.

HOW — Implementing the EHR is a difficult challenge in any healthcare organization. In behavioral health, it’s particularly difficult because of the extraordinary regulatory burden placed on provider organizations by the combination of federal, state, and local funding sources. In Oregon, as counties were completing their specifications for the EHR, one county identified 188

different forms that they use on a regular basis.

Providers must recognize that the adoption of EHRs is much more than simply purchasing software. It represents a cultural and technological revolution. Members sharing their experiences in this issue of *National Council News* highlight that there are two keys to successful implementation — outstanding leadership and intensive project management. The organization’s leadership must drive the revolution, recognizing that it impacts every aspect of the organization’s structure and staff. The project manager must especially focus on bringing all facets of the organization together to collaborate on EHR implementation.

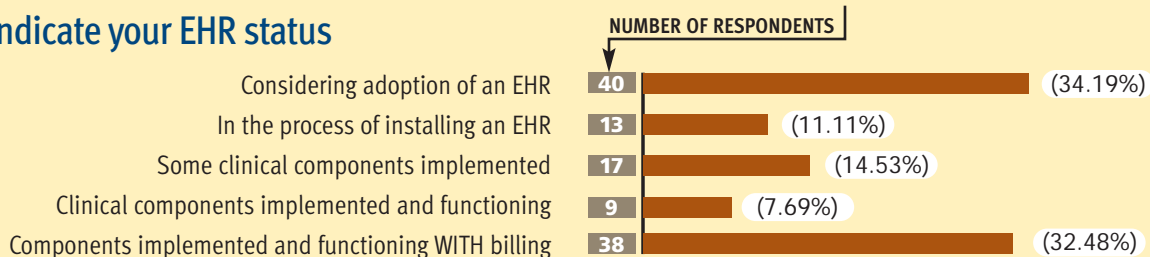
Providers going down the EHR path are rightly concerned about the lack of standards for software and hardware. The federal Behavioral Health Treatment Standards Group at the Substance Abuse and Mental Health Services Administration is working to address this very concern. BHTS comprises mental health and addiction treatment providers, the National Council, national trade associations, technology vendors, and federal organizations. This group was convened in 2004 to ensure that the national standards-setting process for the EHR reflects the needs of behavioral healthcare stakeholders.

In this issue of *National Council News*, a range of providers offer their perspective on EHRs and the promise they hold for our industry. Providers share lessons learned in EHR adoption as well as important predictors for successful implementation. We urge you to use this issue as a guide in your own EHR implementation, and also to take advantage of many other resources the National Council has on this subject, including our listserv discussions, Meet Me Call recordings and sessions at our 37th Annual Conference, March 26 – 28, 2007, in Las Vegas. (www.nccbh.org/vegas). The resources are listed on page 20. And we encourage you to continue to share your questions, challenges, and successes with fellow providers through the National Council.

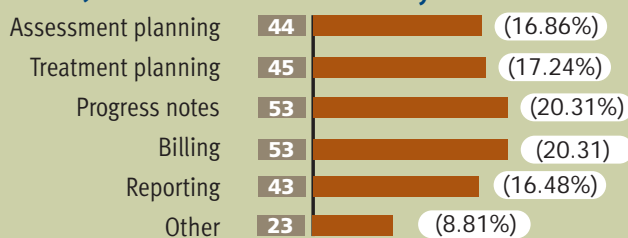
National Council EHR Quick Poll Results

In August-September 2006, the National Council for Community Behavioral Healthcare asked community-based behavioral healthcare organizations across the country about the status of their EHR implementation and the benefits they saw in the EHR. A summary of their responses follows.

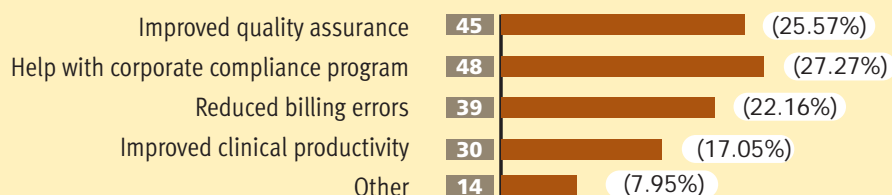
1 Indicate your EHR status



2 If you've implemented an EHR, indicate the functions you've automated



3 If you've implemented an EHR, indicate the return you've realized



Two Sets of Customers, Two Sets of Technology Requirements

Monica E. Oss, Chief Executive Officer, OPEN MINDS

The more I learn about problems with technology adoption in behavioral health, the more I'm sure it's a marketing issue. That's right — marketing.

Follow my logic. Behavioral health provider organizations' rate of adoption of the Electronic Health Record and other technology is spectacularly low, even for healthcare. My interviews with executive teams about their current state of 'wiredness' reveal fairly common reasons for limited technologic functionality: not sure what the future holds in terms of payer technology demands and standards, not enough money to pay for new or upgraded systems, lack of certainty about achieving a return on their technology investment, and

“Executives have to weigh whether their future market will be driven by consumer-directed tenets or pay-for-performance disease management models.”

competing organizational priorities for available money and resources.

You might say that this sounds like a financial issue. I would, in turn, say that all financial issues are marketing issues. So, let's go down the marketing path with this one. First, who are the customers? Customers are those who use, pay for, or influence the purchase of behavioral health services. For behavioral health professionals and provider organizations,

customers include both the consumers and their families who use services and the payers and their intermediary managers who purchase services.

What do customers want? Payers want the provider organizations they work with to have technology to capture a wide range of data in transportable standard formats that help to reduce system transaction costs and permit

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Bringing Behavioral Health Into the Electronic Age

John Carnevale, PhD, Chair, Behavioral Health Treatment Standards Group, Substance Abuse and Mental Health Services Administration

Mental health and addiction treatment providers today face a critical issue — how can they best manage information to improve patient care and safety while protecting patient rights and privacy. Behavioral health is part of the broader healthcare industry, which is in the midst of a massive transformation to better manage patient health information. This transformation has been occurring almost naturally because of advances in information technology and management. It promises an improved healthcare system that will hopefully put an end to the 44,000 to 98,000 patient deaths that occur annually due to preventable information-related mistakes.

sion in a common EHR. This decision must resolve five key policy issues:

1. What unique behavioral health information must be incorporated into an EHR?
2. Should there be time limits on behavioral health information in the EHR — for instance, should a diagnosis of alcoholism be maintained 25 years after sobriety has been attained?
3. What opportunities exist for the behavioral health field to participate in the development of the EHR?
4. What role should behavioral health consumers

Standards Group (BHTS) in 2005. The mission of BHTS is to increase knowledge, understanding, and use of behavioral health data standards in addictions treatment and mental health. BHTS members include a mix of organizations representing addictions prevention and treatment, and mental health services as well as software vendors involved in developing EHRs for behavioral health providers.

BHTS is achieving results. One important result has been to get standards-setting organizations that are shaping the design of the technology and information infrastructure for EHRs (like Health Level Seven), to reflect the unique needs behavioral health patients and providers with regard to privacy and confidentiality. BHTS is also raising awareness and understanding within the public and private sector about the significant potential of EHRs in clinical services and administrative matters, especially for reporting to the multiple entities that fund behavioral health services. BHTS is now working to collect information about the cost of adopting such systems and to learn more about reporting requirements for behavioral health providers. This knowledge will be used to better shape the public effort to make behavioral health part of the transformation occurring in healthcare.

An internationally recognized expert in the field of drug policy, John Carnevale is president of Carnevale Associates, LLC, a public policy firm that offers guidance to governments, organizations, and communities as they confront the public policy and program challenges of the 21st century. At the White House Office of National Drug Control Policy, he directed the formulation of the President's National Drug Control Strategy as well as the federal drug control budget. He has also worked as a researcher at the Office of Management and Budget and in the U.S. Department of the Treasury in the Office of State and Local Affairs.

“Information technology used in behavioral health is a far cry from fulfilling the potential to improve clinical decision-making and program planning.”

The federal government is participating in healthcare's information technology transformation. In 2004, President Bush issued Executive Order 13335 that called for the widespread adoption of information technology in healthcare and established the Office of the National Coordinator of Health Information Technology (ONCHIT) to help achieve this goal. To a service provider, the Electronic Health Record may sound like a software issue, but it is in fact a retooling of business practices affecting patient safety and quality of care.

How can behavioral health become part of healthcare's information technology transformation? Behavioral health providers must first decide on essential mental health and addictions treatment information for inclu-

and service providers play in actively managing behavioral health information and other data standards?

5. How should the EHR address privacy and confidentiality?

How is the behavioral healthcare faring so far in this transformation? Not very well. Information technology used in behavioral health generally supports only administrative reporting and is a far cry from fulfilling the potential to improve clinical decision-making and program planning.

To help behavioral health better react to this transformation, the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment sponsored the Behavioral Health Treatment

Caveat Emptor — Standards Are Essential but Won't Spare Providers the Homework

Jim Kretz, Project Officer, EHR & PHR Project, Substance Abuse and Mental Health Services Administration

Interoperability is key to the success of Electronic Health Records, but there are many barriers to sharing data between systems, according to David Brailer, M.D., national coordinator for health information technology. The major challenges include lack of standards harmonization, unclear data control policies, a lack of uniform security practices, the inability to ensure that products perform as advertised, and the lack of a business model around interoperability.

While many organizations are involved in developing and approving standards, there isn't a process for harmonizing various sets of standards. There is obviously an urgent and critical need for uniform national standards and product certification to determine which EHRs are robust, interoperable, and secure. This will help to accelerate the adoption of technology as providers are currently apprehensive about investing significant dollars in products that might not be compatible with other products in the long term.

A number of federal efforts are underway to support the creation of a National Health Information Network that will establish standards for EHR products. Academics, caregivers, software vendors, and standards development organizations are all involved in these efforts. These efforts are primarily being carried out by the American Health Information Community, the Office of the National Coordinator for Health Information Technology, the National Committee on Vital and Health Statistics, the Health Information Technology Standards Panel, the Department of Veterans Affairs, the Department of Defense, the Indian Health Service, the Centers for Medicare and Medicaid Services, and the Substance Abuse and Mental Health Services Administration. Because so many people and organizations are involved in so many undertakings on so many different time frames, the notion of headless chickens might come to mind but that would be a bit unfair.



Even after the institution of national standards, providers will need to evaluate every application based on needs and requirements.

SAMHSA is currently hosting a large group of substance abuse treatment and mental health service providers, software vendors, insurers, state and local officials in the development of a Behavioral Health Conformance Profile corresponding to the Health Level 7 Electronic Health Record Functional Model. As a result of an email from SAMHSA center directors, direct appeals to various organizations, and addressing a group at the National Council's 2006 Annual Conference in Orlando, more than 130 people initially expressed an interest in participating in the Profile project. More than half of these people and organizations are participating in the conference calls, during which detailed functional capabilities are identified and modified, one by one and hour by hour. Issues of privacy, security, and access are also being examined.

After these and similar efforts regarding the National Health Information Network are complete, the Certification Commission on Health Information Technology will test and certify various software packages as genuinely incorporating these standards and requirements. However, standards and certification do not represent the ultimate solution. When considering EHR adoption, providers must focus on planning and defining their needs. They must identify their business and clinical requirements. They must carry out a business analysis to help determine what an organization can reasonably expect to gain in resources

and return on investment. They must then use EHRs as tools, not as end-points in themselves. If an organization implements any system without a clear set of objectives and reasons, the system itself will become the problem rather than the solution.

Even after the institution of national standards, providers will need to evaluate every application — whether it is a web-based application or is to run on internal hardware — for

- Ease of use
- Ease of learning
- Speed and responsiveness
- Ease of integration with existing application package
- Impact on current organizational processes

Herein lie the potential “gotchas” that can ruin a significant investment in the Electronic Health Record. Systems that are not evaluated in the context of real needs might work as documented according to standards but could yield completely unexpected outcomes.

Standards are essential but they are the beginning, not the end of the road.

The Substance Abuse and Mental Health Services Administration has designated the Behavioral Health Treatment Standards Workgroup to help coordinate the behavioral healthcare field's ongoing informatics standard-setting and related initiatives.

Exploring the Power of New Technologies *Continued from page 1*

must be tuned into and how are these challenges best addressed? Here are some perspectives based on the experiences of a provider and vendor.

Role of CEOs and Project Management

First, we must remember that successful implementation of the EHR is more of a management issue than a technical issue. The role of executive management in the provider organization can make or break the deployment of the EHR. The CEO must recognize the need for skilled project management in EHR implementation and assign the best project manager to lead the implementation. The project manager must have the organization's unwavering commitment as well as the resources and support for success.

CEOs must not feel compelled to demonstrate a technical competence they may not have believing the primary issue is technological. But neither must they delegate all solutions to the IT or project manager. CEOs should:

- Be involved in the early planning meetings where critical goals are addressed.
- Establish a regular reporting expectation to review the program.
- Be prepared to take on formal decision-making and dissemination of directives and assignments.
- Present recommendations to the board for policy decisions.

Software Evaluation and Process Reengineering

Vendors will often sell software based on its potential return on investment. A candid vendor will also note that this ROI is only possible if organizational, procedural, management, and supervision changes are made by the provider. Processes designed for manual recordkeeping must be revamped focusing on automated EHRs. These changes might be as simple as shifting minor duties among staff at a location or as extensive as centralizing a number of processes currently being performed in the field or retraining a large number of staff. The vendor can support these process

changes but cannot cause them to occur.

In evaluating software, providers should:

- Identify each operation of the software and determine the most efficient method of performing that operation.
- Identifying the staff who will perform, supervise, and manage each operation.
- Develop and document new procedures to achieve improved efficiency in each position and identify processes that should be eliminated.
- Familiarize operational, supervisory, and management staff with the new procedures and support tools available to them.
- Plan a cutover method for ceasing the old processes and starting new ones.
- Determine how this cutover method will interleave with the deployment of the EHR software.

The EHR will yield ROI only if organizational, procedural, management, and supervision changes are made by the provider.

A good way to plan EHR implementation is to visualize how the software would be used most efficiently in a startup agency and then determining the changes required in an established agency to accomplish that optimum operational model.

One danger is that staff that are not adequately trained and tuned into the mission of the EHR will not only adopt the new processes required for automation but continue performing the widowed processes, actually increasing your operating costs. This effect has often been noted in case studies of EHR implementations, sometimes without recognizing the cause. Executive management oversight is critical to ensure that the reengineering takes place; to review, revise, and endorse recommendations; and to assure that available

efficiencies and quality of care potentials are continuously improved. An example from the Austin Travis County MHMR Center is air card utilization reports highlighting wireless data entry. Outliers in these reports come under supervisory inquiry for service productivity, inventory and/or redistribution.

Once you have a vision of the reengineering requirements, the project leaders from the provider and vendor organizations can oversee the configuration of the software to reflect the new operations method. Procedures can be revised as needed to reflect the actual capabilities of the software. The provider's CEO can review and approve final results.

Equipment

Equipment (networks, communications, recommendations, setup, operation, maintenance, upgrade/replacement schedule, et al) is again a management issue, not a technology issue. Understanding this and having a few guidelines makes the implementation of EHRs less daunting.

The largest single cost for mission-critical equipment is the personnel to set up, maintain, and support the equipment. It is difficult for non-technical people to hire technical talent. Behavioral health providers also cannot afford to pay the competitive salaries that top talent demands. However, just because you own a bus does not necessarily require that you have mechanics on staff or that you buy instead of lease the bus. The same concept applies to owning and operating the equipment versus the vendor's ASP Hosting option.

If you currently have a capable IT manager, we recommend that you consider the vendor's ASP hosting option. If you are certain you currently have a good IT manager and solid supporting IT staff, then it is best to manage your technology in house and delegate to your IT department the upgrade of equipment as necessary but establish a management directive to follow vendor recommendations. It is rare now for vendors to sell both software and equipment. So your software vendor will be sure to recommend equipment and setup methods best suited to the software.

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Exploring the Power of New Technologies *Continued from page 6*

If you are uncertain of the ability of your IT manager, consider his or her experience with mission-critical applications, record in regard to stability and speed of your network, experience with the particular technology recommended by the vendor, and acceptance of the vendor's recommendations for equipment, setup, and operation.

If you are confident in the capabilities of your IT manager but want extra assurance that the equipment will adequately support your application, then require the vendor to install and setup the recommended equipment and require performance language to ensure that the equipment is adequate to meet your needs.

Anasazi's experience is that approximately a third of all implementations run into trouble over equipment. If this happens, it reduces your ability to focus on the truly critical aspects such as configuring the software to meet your needs; dealing with the cultural change and acceptance of clinical staff; and training, support and deployment issues. There are proven solutions to the technology aspects of equipment issues. Do not be penny wise and pound foolish when it comes to equipment.

Finally, adequate attention to staffing, change management and process reengineering, and software and equipment issues will all contribute toward successful EHR implementation in a community behavioral health organization.

David Evans has served as the executive director for the Austin Travis County MHMR Center for the past 13 years. Mike Morris is the co-founder and president of Anasazi Software, Inc. They both serve on the Behavioral Health Treatment Standards Workgroup, supported by SAMHSA and SATVA, and established to define a strategy for behavioral health information and its role within the nationwide health information infrastructure.

The Intersection of Corporate Compliance and the Electronic Health Record

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comprehensive compliance philosophy. The EHR-led technological culture shift in operational and clinical practices has allowed us to build a level of corporate compliance consistent with state, federal, and accrediting body requirements.

We individually addressed hundreds of regulations from all program perspectives through each phase of the EHR implementation process. Along the way, we often redefined the ultimate look and function of records. It was a daunting task but we achieved significant systemic increases in the compliance level of our programs through improved timeliness of clinical entry; availability of real-time data and information for clinical, operational, and fiscal staff; monitoring of clinical practices; reduction in billing documentation issues; and compliant plans of care. Performance management trend lines have been positive and the emphasis on compliance has not negatively affected clinical outcomes or consumer satisfaction.

A few guiding principles emerged during our EHR implementation:

- The project team must represent all staff levels within the organization.
- All project team members, especially the Corporate Compliance Officer, must have an accurate and complete understanding of all state, federal, and accrediting body rules and regulations (i.e. reading what the rule does not say as much as what it does say).
- Much of the EHR must be built around the rules and regulations.
- The organization must accept that corporate compliance and the accompanying auditing functions will never be 100% automated.
- No matter how sophisticated the information system, the answer to questions such as proving Medical Necessity always lies within the documentation.

Overall, NCBHS' return on its investment in the EHR has been enhanced due to integration with our corporate compliance program — this has reduced the costs of necessary monitoring and potential financial paybacks. The design, development, and implementation of a compliance-driven EHR has advanced our overall mission and viability as well as our operational and clinical health.

To learn more, email Mike Lau at mlau@ncbhs.org



Your EHR Questions Answered

Dennis Morrison, PhD, and Grady Wilkinson answer community behavioral health providers' frequently asked questions about implementing the Electronic Health Record

Q. What are the clinical benefits of using an EHR?

A. The clinical benefits are many and arguably provide the most compelling reasons for moving to an EHR:

- EHRs provide a legible record. This seems mundane but the reality is that many of our records do not get used as reference documents because they are illegible.
- EHRs result in more structured and standardized treatment planning, progress notes that are linked to treatment plans wherever possible, and ultimately the implementation of Clinical Decision Support Systems to provide feedback to clinicians to help enhance their treatment services (CDSS is not well known or implemented in behavioral healthcare but that will change as we become more data-oriented like the rest of healthcare).
- EHRs make records available in real time at any time and anywhere a client needs to be seen.
- The integration of standardized clinical outcome measures into the clinical workflow will enhance treatment significantly.

Plus, you'll be able to move information quickly without repeating it, eliminate redundant data collection and entry processes, streamline services from delivery to documentation to billing, and improve corporate compliance levels. These and other efficiency gains will come naturally if you focus on the power of EHRs to add value to your client care process and serve the clinical functions of your organization.

Q. Who should be included in the project management team for implementing the EHR?

A. The obvious participants are the IT and financial folks. However, for successful implementation, it is important to also include frontline users of the critical functions being

automated. Having clinical staff on the team will provide greater insight into how the EHR can serve and strengthen the clinical processes of your organization. The same can be said of clerical, billing, and other corporate functions. In the design stage, you want people with

Top 5 Questions in EHR Implementation

- *What are the clinical benefits of EHRs?*
- *Who should be on the implementation project management team?*
- *How do I address staff resistance to the EHR?*
- *How do I pick a vendor?*
- *What determines the length of the implementation process?*

some level of computer competency but in the testing phase you want to have a mix of experienced and inexperienced computer users. Those who are computer literate can anticipate things that novices cannot. Having the less experienced users test the system will uncover workflow and user interface problems that a sophisticated user will miss and also help to determine the levels and types of training and helpdesk required to provide to assure successful EHR implementation.

Q. How do I address staff resistance to implementing an EHR system?

A. Staff resistance is one of the most difficult aspects of EHR implementation and should be considered every step of the way. Here are some ways to address it:

- Let staff know early on that the leadership is serious about the EHR initiative. The message from the top must be unambiguous — this is the way the organization is going and 100% of the staff will be expected to use the EHR. At both of our organizations, all employees had to pass a competency exam on the test database before they would be given a log-on to the real database. We each made passing the exam a condition of employment for new staff and

of continued employment for existing staff. While this may sound harsh, the reality is that you can't have part of your staff using an EHR and the other half doing something else. This is an initiative that is a whole-sale change for the organization and its culture and those who don't want to participate in a culture using EHR are probably better served working elsewhere.

- Bring staff into the discussion early so the EHR does not come as a surprise. Include on your project management team line staff representative of critical corporate functions.
- Work on greater staff buy-in and increase the number of internal project champions. Have staff participate in testing and utilization of the system during development so they will take ownership in the implementation and see the value of the EHR. Use staff feedback to improve the user friendliness and value of the final EHR design,
- The project planning team should consider marketing of the EHR as a legitimate function to be incorporated into the plan. At Heritage, a "Marketing Team" was established to promote the coming of the EHR and through a variety of creative and entertaining activities and sparked a great deal of positive interest in the project.

Q. How do I pick a vendor?

A. The critical albeit, overly simplistic principle is to know what you want the EHR to do and the problems you are looking for it to solve. There are several different ways to approach this. The most traditional route is to identify a set of functional criteria that are needed to conduct the business of the organization and summarize those in the form of product specifications. Vendors will then respond and offer to demonstrate that functionality for you.

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EHR Questions Answered

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The most valuable way to tell if a particular vendor's software does what it purports to do is to actually see it in action. So, the more site visits to where the software is implemented, the more likely you are to see the "real thing." This is an important part of the selection process and you should take fullest advantage of these opportunities by sending several members of your team. You will also gather potentially valuable information on how others implemented the software, their positive and negative experiences, and the value they believe they've derived from the EHR.

It may also be helpful to identify the architectural criteria for the software such as the type of database, the operating system, the preferences between proprietary and open-database systems, etc. Identifying these aspects before choosing the functional criteria of the software was important to us because we

believed that no vendor — no matter how good — could meet 100% of our needs. So, we preferred to be sure that the software was flexible enough that we could hire programmers, or write our own code, to get the last 20% of the functionality we needed. Not all organizations want or need this level of flexibility. In fact, if there aren't many internal resources, an organization is probably better modifying its business practices to adapt to the software rather than the other way around.

Q. What determines the length of the EHR implementation process?

A. Effective leadership will shorten the process considerably. We know of some organizations that are on their second implementation of an EHR and are still not successful — the problems are not related to the vendor but to the leadership of the organization. Staff resistance that is not dealt with effectively will extend the implementation process.

The implementation process will also vary according to the sophistication and degree of customization required in the software. The easiest and shortest implementation and is one that uses the software "out of the box." Any software that must be customized by the vendor for unique applications will take considerably longer. For Center for Behavioral Health, the implementation and training started about a year and a half prior to the "go live" date; for Heritage Behavioral Health, it took significantly longer, in part because of the extensive re-engineering and in part due to changes in the ownership of the software vendor. A caveat for CEOs: driving an implementation too fast is arguably more dangerous than taking too long.

Dennis Morrison is CEO of the Center for Behavioral Health in Bloomington, IN and Grady Wilkinson is President of the Sacred Heart Rehabilitation Center in Memphis, MI. Both have led their own and other provider organizations in extensive EHR implementation projects.

Two Sets of Customers

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more accurate management of consumer care. Consumers want providers to have technology that facilitates convenient knowledge of available service options and their efficacy, easy online access to personal health information, convenient scheduling, and streamlined communication with the professionals within the provider organization.

It's easy to see why payers want providers to have systems that gather all clinical information in an electronic record that can integrate with regional health networks. Almost all analysts agree that electronic Medical Records would save lots of money in the delivery of healthcare. But I'm not so sure consumers care. And where are the provider organizations in this cost equation? According to RAND Corp. Senior Management Scientist Richard Hillestad, PhD, the disjointed nature of funding in U.S. healthcare results in the majority of the financial benefits of EHR accruing to payers, rather than to the provider organizations that pay for systems.

Given the chasm between what consumers want and what payers want, you would tend to go with the money and give payers what they want. But this is probably a good choice only if you think:

- Payers really are at a point where they know what they want and need for their systems management in the long run
- Payers have a great influence on consumer selection of your program

The issue of competing customer priorities for available resources is not easily resolved. David Garvin, a prolific author on market-related issues, has written about strategic quality as a means to compete on dimensions of customer quality differentiation. His strategic quality framework is based on the notion that our market position should be clearly based on one or more customer-focused quality dimensions and that positioning should drive our prioritization of organizational resources. In his model, executives simply need to know and quantify what their customers' preferences are in order to make resource allocation decisions.

Not so simply, provider organizations have two distinct customers with two distinct sets of technology-related requirements. And executives have to weigh whether their future market will be driven by consumer-directed tenets or pay-for-performance disease management models.

In this situation, executives have two options: wait until we know for sure the direction of the market and then make technology decisions, or make an informed and well-researched decision on the future of your particular market and proceed at a reasonable pace. The former will never happen — or will happen too late for most organizations. The latter is why they pay leaders the big bucks.

Monica E. Oss is the CEO and founder of OPEN MINDS, a national behavioral health and social service industry market research and management consulting firm. She is a featured speaker on and author of numerous books and articles on industry trends and strategic marketing and management issues. She has a broad range of executive experience in both the private and public sectors of the behavioral health and social service fields.

Electronic Health Record Roundup

Behavioral health providers considering adoption of the Electronic Health Record have much to learn from others that have already been down this path. In this roundup, community-based behavioral health providers across the country share lessons learned from success and failure, describe how they have overcome challenges and resource constraints to take this important step toward quality of care, and comment on how the EHR has transformed their organizations.

EHR Supports Effective Clinical Care and Opens Up Potential at Centerstone

Thomas W. Doub, PhD, Vice President for Research and Karen H. Rhea, MD, Vice President for Medical Services, Centerstone, Nashville, TN;
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Centerstone has a staff of 1,000 serving more than 50,000 individuals and families at 66 facilities located in 26 counties throughout Middle Tennessee.

We've used electronic systems since 1983. Our early software tracked encounters, human resource activities, and financial information but did not interface with or support clinical operations. Our clinical operations were based on paper records, which not only generated an extensive need for medical record storage. Paper systems were not able to meet several needs such as

- Sharing records across multisite programs and facilities.
- Remote access to client records.
- Real-time documentation.
- Unified client information/medical record.
- Automated smart scheduling.
- Strong system edits for posting/billing requirements.
- Accurate and efficient medical record audits.
- Security with HIPAA compliance.
- Medication log with legible entries.
- Data mining capability for research.

Fortunately, each of these needs has been met to a significant degree since March 2003, when the customized, web-based commercial Electronic Health Record that Centerstone started implementing in 2001 was extended to medical staff. EHR implementation fostered considerable organizational change with a shared sense of pride and ownership in utilizing and an improvement in marketable skills for individual professionals.



We learned many lessons during EHR implementation. Training for all staff and a strong mandate from agency leadership created a high level of rapid staff adoption. Implementing medical providers separately and at the end worked well, especially with fairly extensive training and careful attention to feedback on the test system. However, an underestimate of the vendor's ongoing commitment to problem resolution led to a failure to address aberrant programming issues in a timely manner.

Despite the many benefits of a web-based medical record, this initial EHR product is simply an e-version of the prior paper record. As we look ahead, there is clearly a need to harness the work efficiencies of advanced computer technology in medicine, such as e-prescribing with edits interfaced to a database for dosing and drug interactions. Computer-assisted diagnostic screening can lead to more accurate diagnosis with better identification of comorbid disorders – truly a prerequisite for evidence-based treatments. Computerized diagnostic screenings will also increase recruitment for research. Also, with

regard to enhancing research, reduction of messy data in text boxes will allow for more granular and accurate data mining. A Computerized Decision Support System will provide valuable real-time feedback integrated seamlessly into the clinical workflow. Self-ratings performed in kiosks will provide crucial clinical data at the time of the visit, essential to measurement-based care and outcome monitoring.

In order to develop a system that is more responsive to organizational needs and our clinical vision, Centerstone brought the maintenance and development of its EHR back in-house. We are now moving forward with development of an entirely new generation of EHR that provides enhanced functionality to support improved clinical care through streamlined workflow and clinical decision support capabilities. This represents a significant departure from previous generation products that did not fully leverage the power of computers. We hope this will ultimately lead to better services and improved lives for those we serve.

SEKMHC Realizes Need for a Data Plus Document EHR System

John Helton, PhD, Licensed Psychologist, Director of Clinical Services, Southeast Kansas Mental Health Center, Iola, KS; jhelton@sekmhc.org

In 1994, Southeast Kansas Mental Health Center implemented the Lavender and Wyatt Systems, Inc. base billing and accounting software applications. In 1999, we added their clinical document system, which reduced delinquent progress notes to zero and allowed third parties to conduct Utilization Review remotely, providing clinicians with “outside” feedback on quality and timeliness. Since it is a document-based system, reviewers quickly understand how to locate information in the electronic records. Recently, case managers added their laptop documents to the system via wireless connections at the eight networked offices. The document templates are easy to modify and have evolved to address many compliance challenges.

However, a document-based record system has limitations. Documents are not data. Once information is on a page, whether paper or screen, compliance can only be addressed by viewing each document. Improvement requires management of elements in the record.

In September 2006, we completed a major upgrade of our EHR, after a 2-year design process, with the same vendor, LWSI. The upgrade links to the existing document system. The design process for the upgrade required careful consideration of trends in compliance, different state requirements, different standards of care (e.g., urban versus rural), limitations on staff time, ways to productively involve clients despite their different levels of computer acceptance, realistic communication barriers among team members, and ways to continue the intuitive acceptance of the EHR.

The EHR upgrade addresses challenges such as the desired applets for a browser based portal interface with assessment data individ-

ualized to each center:

- Kiosk and secure web client self-assessment.
- Thorough diagnosis support.
- A treatment plan builder, which suggests problems, goals, objectives, and interventions for, assessed symptoms; improved scheduling (including a method to allocate clients to fill groups).
- A clinical support library.
- A single view of information important to the client’s treatment team — client alerts, team members, medications, past and future service appointments, and client contact information.

Back office records management and improved prescription applications are currently being designed.



The new EHR system is much more thorough. Qualified team leaders certify data without the previous printing and routing of documents for staff review. Team members stay current on life events and progress by tagging new data for review. If orders are not current, services may not be scheduled. The treatment plan now is truly dynamic. Client authorizations to release information also are automated. Alerts are provided so staff knows what information can be shared with whom.

Future challenges include resolving the difficulty in mapping state paper forms and proprietary outcome instruments because of the fixed nature of the questions and permissions to disassemble forms. Yet, all the assessment questions important to treatment need to be in a single assessment view. Another challenge is the automated synchronization of laptop data. Currently, this is done manually at significant expense of time and effort. Further, some community-based staff must still use paper forms, since it is too expensive for each psychosocial program aide to have a laptop or must take turns using one.

In fact, EHR development is an ongoing process. A flexible, data-plus-document system continuously adapts to changing requirements of compliance and managed care. The ability of each center to use solutions of other centers decreases waste. Our EHR development benefits significantly from LWSI’s Clinical Advisory Group, which evaluates and prioritizes worthwhile requests to improve the system. The group comprises nine clinicians from three community mental health centers in different states, which range in size from small to large. These clinicians have been instrumental in helping to define system improvements and solutions through a healthy process that suits clinicians and clients rather than programmers.

Washtenaw Uses EHR for Behavioral Health and Primary Care Coordination

Jeremy Nelson, National Council Consultant and Chief Information Architect, Washtenaw Community Health Organization, Ypsilanti, MI; nelsonje@ewashtenaw.org

Primary care and behavioral healthcare have been historically segregated in the United States. Now with the explosion of Electronic Health Records, we have the opportunity to integrate the two more than we ever thought possible. Many components of treatment can easily be shared once the information is collected digitally. Prescriptions, vital signs, lab results, radiology results, allergies, and referrals are among the most common elements that can be collected in both settings. Sharing this information will increase the level of health assessment before the clinician sees the consumer.

Community behavioral health providers must certainly consider partnering with local primary care clinics or hospital systems to develop and share an EHR. But before any information can be shared between EHRs, a lot of ground work and relationship building must happen between your agency and your local primary care organizations. Much time must be spent cultivating those relationships around trust and patient care. Then, it will be much easier

to interface the EHRs and implement technological solutions.

The Washtenaw Community Health Organization partnered with four primary care clinics in Ann Arbor, Michigan to deliver integrated behavioral health and physical health services. We've placed social workers and part time psychiatrists in the primary care settings to help facilitate the integration and coordinate the care. We invested in a year's worth of relationship building with the primary care offices before there was ever a discussion around sharing data and developing an EHR. Washtenaw then brought to the partnership the extension of our EHR, Encompass, to provide primary care modules to our partners. The result is a truly integrated medical and behavioral health record that is shared between primary care physicians and behavioral health clinicians. The Encompass system has been designed to meet all HIPAA requirements for privacy and security while allowing the controlled flow of information between clinicians and physicians. Through electronic

consents for treatment and a series of user group and function controls, we can share information about consumers that are admitted to both programs, for fully integrated healthcare.

Lack of standards in how information is collected and how it can be transmitted is causing many organizations to wait before moving forward with an EHR. However, there are measures that you can take to ensure that the EHR system you choose now will grow with your business and conform to standards as they are finalized. Make sure to check with the EHR vendor if they have an open platform that will allow customizations and ongoing refinements. Also check with the vendor to see what their plan is for adhering to the CCHIT EHR standards as they become available.

The EHR can certainly be a catalyst to expedite the transfer of information between behavioral health and primary care, but without the right relationships, the best EHR will fail.

Going Wireless — Verde Pioneers EHR Applications for Rural Settings

Richard Dehnert, Community Relations Coordinator, Verde Valley Guidance Clinic, Cottonwood, AZ; RichardD@VVGClinic.org

Verde Valley Guidance Clinic, with its rural small town base, was perhaps among the first behavioral health providers in the nation to make a complete clinical transition from paper information collection to electronic information entry. What started with the installation of networked desktop computers in the offices of each clinician has evolved and expanded to incorporate the remote wireless communication system used by staff out in the field, visiting and caring for individuals with serious mental illness and other health issues in their homes.

The use of laptop notebook computers enables staff to work anywhere in the community without losing touch with their colleagues; without having to return to the office to do hours of

paperwork; and with the knowledge that they can access treatment plans, case management notes, future appointments, and psychiatric records for each client.

Mobile technology enables a Verde Valley worker in the field to send an instant message or email to the client's case manager, or to ask a member of the medical staff questions about a client's medication. Appointments can be set for adult team meetings in which the client, family members, and the client's clinic treatment team can review the client's progress. During or shortly after each visit with a client, the behavioral health technician, therapist, or other team member can document the service provided and the client's condition in a progress note, set the

next appointment, and send the data by wireless connection to the clinic's Medical Information System. The worker's paperwork is done before they leave the client's driveway.

Community mental health workers who formerly kept track of their daily activities on an unsecured pad of paper, post-it notes, and napkins, now use their clinic-provided laptop computers. The clinic's behavioral health technicians, vocational rehabilitation specialists who work with clients in training programs and as job coaches in the community, crisis counselors who meet with clients at the hospital emergency room or elsewhere, and intake counselors who might be called to

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conduct screenings and mental health assessments in the county jail all carry the wireless laptops.

Documentation which formerly took two hours or more per day is now done at the time of each visit, wirelessly transmitted to the MIS, and printed out in the clinic's medical records department for retrieval at the worker's convenience. Soon the clinic's billing will be tied directly to the notes generated electronically by clinicians, eliminating the need for paper service activity logs and hard copies of the supporting documents.

Verde Valley Guidance Clinic began the rollout of its electronic clinical documentation system in July 2001. Working with a company known as CMHC at the time (now Netsmart), the clinic began implementation of a system dubbed eCET. The decision was made to conduct a complete agency wide transition to eCET with only one month of preparation by "end users" or clinical staff. Clinical staff was involved in the planning process and supported with training and orientation. Staff was asked to understand how the use of eCET benefits them, the client and the agency, and was told that this innovation was in keeping with "the prevailing organizational culture and organizational vision."

The cultural change and its affect on clinicians was enormous, but was quickly overcome, mostly because there was no choice. Many clinicians didn't feel comfortable moving to electronic data entry, even though they had lamented the labor intense paperwork required of most behavioral health care providers. But CEO Robert Cartia's approach, "Include them, train them, support them, but don't give them a choice. Also, find champions within your organization and train them first. Let your champions become your trainers and they will be a resource that pulls everyone else along," worked. Not one staff member left the agency due to eCET.

Once the in-house MIS system was established, the clinic began looking for mobile solutions to facilitate the delivery of services beyond the walls of the office. The first attempt involved the issuance of PDAs to clinicians conducting most of their work out of the office. But typing case management notes on tiny keypads and less than reliable connectivity resulted in abandonment of the PDA project after several frustrating months. The answer was laptop or "notebook" computers with wireless dial-up connections.

Several problems had to be addressed. Medically sensitive information had to be transmitted from the end of a dusty road in the desert to the clinic's MIS computer without compromising a client's right to confidentiality. And what would happen if one of the laptops fell into the wrong hands? Could an accomplished technician access information saved on the computer's memory? The answer was a fleet of laptops without hard drives, but with a secure encrypted connection to the network. A clinician in the field can tap into the clinic's network and access or send information as if they were sitting at

their desktop back in the office.

An added benefit is the reduced need for office space. As staff grows, it's easier to share an office with a worker who isn't there. In fact, it was the clinic's willingness to trust technology, and to allow staff members the freedom to work out of the office that led to the discovery of a technological "silver bullet." For example, the clinic's network administrator, Steve Barrow, moved to Chicago but continued to work for the clinic. It worked. Clinic staffers who ran into problems found that they could call, instant message, or e-mail Steve from their desks at any of the three clinic offices, and receive his assistance as if he were just down the hall.

The Verde Valley's topography presented another problem. Although the area is served by a number of cell phone towers, the signals are spotty due to the mountains and deep canyons, which limit coverage. The answer was a selection of "aircards" from different cellular companies. An "aircard" is basically a tiny antenna tuned to a particular frequency

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that plugs into the side of a laptop computer. If a worker finds himself or herself in an area with no signal to connect to the network, they can try “aircards” from different providers until they find the one that works.

While the system hasn’t been in use long enough to produce a statistical analysis of its effectiveness, some results are apparent. The system has resulted in more timely and accurate documentation of the clinic’s services, which supports prompt billing with payors; increased efficiency in service delivery; happier employees who spend less time on paperwork; and most importantly, more time and better service for patients.

Verde Valley Guidance Clinic is the recipient of Qualcomm’s 2006 3G A-List Award for innovative, successful wireless data solutions.

Do’s and Don’t s in Implementing the Electronic Health Record

Jerry Mayo, Executive Director, Pine Belt Mental Healthcare Resources, Hattiesburg, MS; jmayo@pbmhr.com

Do be aware of the hidden costs. Beyond hardware and software, you will incur costs for communication lines, additional IT support staff, lost productivity upon implementation, and possibly the cost of trying to run dual systems depending on how you implement your new software.

Do have multiple demonstrations of the product(s) you are interested in purchasing. The more you review, the more you will see that will affect your implementation and utilization.

Do go to the agencies where the software is being used.

Do ask for a list of all users of the product you are considering. Randomly call some of the users and question them about the product and support.

Do not accept the vendor's first contract submission. The contract is all in the vendor's favor.

Do not pay before you get something. To the extent possible, base payments on performance.

Do not underestimate the time required for implementation.

Do not assume all of your staff have the necessary computer skills to operate an Electronic Health Record.



EHR Guidelines and Tools for Executive Management A Summary of the MHCA-SATVA Paper

Robert Beckwith, Information Technology Manager, National Council for Community Behavioral Healthcare

The Mental Health Corporations of America and the Software and Technology Vendors Association constituted a joint task force to produce the paper, “Planning Your EHR System: Guidelines for Executive Management.” The paper offers best practice guidelines for the successful purchase, implementation, and ongoing development of Electronic Health Record systems and for related, mission-critical business and clinical functions.

Written by and for executive management, the paper answers some of the basic questions that organizations encounter in EHR implementation, taking into consideration both the provider and vendor perspective. The paper outlines the value and importance of an EHR and the general principles for successful implementation. It also provides extensive guidelines and tools on two critical areas — assessing your organization’s readiness and needs and selecting a vendor.

The paper reiterates that the planning, acquisition and implementation of an EHR is “a tedious and introspective task.” Such things as the need for narrative clinical information, lack of diagnostically based treatment protocols, and community based programs that have encouraged local styles of business all complicate the application of technology. Furthermore, the EHR’s impact on financial and human resources is substantial — nothing else you institute will ever envelope as many human and institutional resources and systems. On the upside, though, “there is tremendous potential for the EHR to enable and facilitate significant improvements in clinical practice, client safety and client outcomes.”

What does it take to implement a successful EHR?

It starts with active executive leadership and project management throughout all phases, including ongoing oversight before and after implementation. Executive management, in acting as the project sponsor, should appoint a project leader, develop an organizational readiness assessment, and define the scope of the

project. Management and the project leadership must communicate the value of an EHR to the various stakeholders, while not losing sight of the ultimate value — enhancing clinical practice.

The potential benefits of an EHR to your organization will be clarified by a request for information (RFI) and a request for proposal (RFP). The RFI can act as an outline of the key capabilities of the technology and will form the basis of your initial assessment and will, in a sense, act as your “wish list.” The RFP will further define your goals, which might include the longitudinal collection of electronic information relating to an individual’s health and healthcare, access to this information and application of knowledge and decision making to support quality, safety, and efficiency of patient care. There is an excellent model RFP, appended to the report, which encompasses issues such as vendor site visitations, third party software requirements, and training.

Organizations with well defined billing procedures, forms and clinical processes — especially systems of evidence based practices or clinical workflow — should look for software that can conform to established systems. Other organizations with less developed systems, or systems in need of overhaul, should look for software that will help to retool, while many organizations will use a combination of the two. The organization assessment, provided on page 18 of the paper, should be used before proceeding to the next step — acquisition.

The paper recommends that you approach a software vendor only after you have determined the purchase criteria. Organizations making a first purchase typically rank price and ease of implementation as most important purchase consideration. Organizations making subsequent purchases of an EHR rank support and vendor choice as the most important. A good relationship with the software vendor, along with strong project management and leadership, are essential for successful implementation.

With a positive outlook and plenty of hard work, your organization can survive the decision to go with an EHR and reap enormous benefit. Besides, resistance is futile. The MHCA-SATVA paper is a must-read for behavioral healthcare and human service organizations going down this road for the first time. Executive management will especially appreciate the comprehensive and real-life perspective as well as the practical tools such as the Organizational Assessment Tool, Contract Negotiation Guidelines, and RFP recommendations.



Learn More

“Planning Your EHR System: Guidelines for Executive Management” is available at www.nccbh.org (see Links and Resources).

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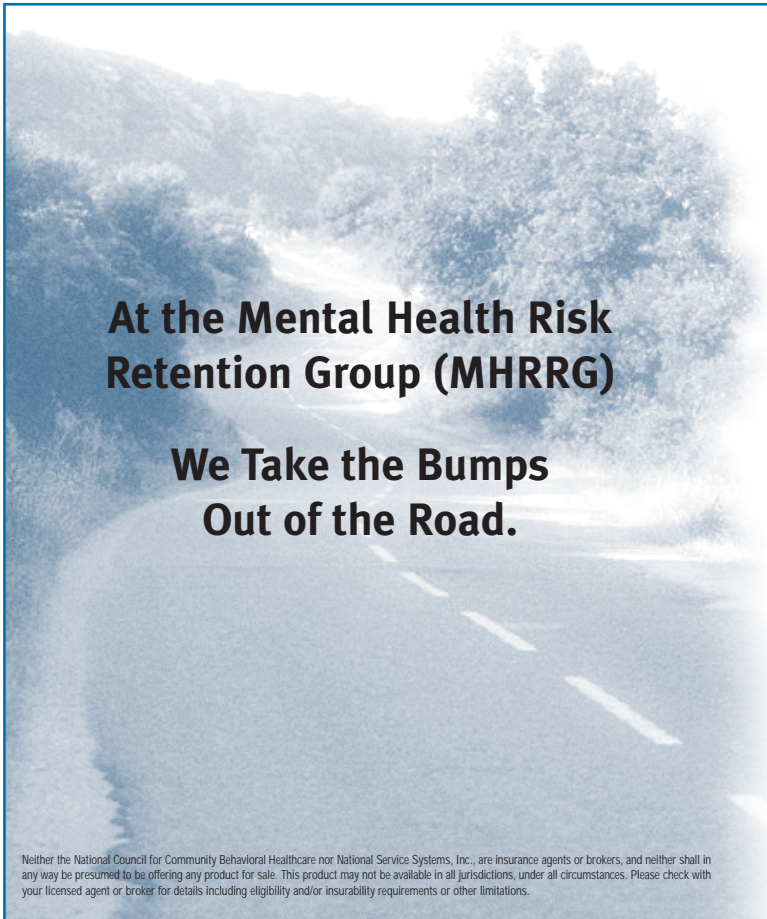
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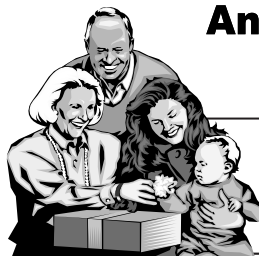
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Resources to Implement the Electronic Health Record

The National Council congratulates the Center for Behavioral Health in Bloomington, IN for receiving the prestigious 2006 Davies Award for excellence in EHR implementation. Applications for the 2007 awards are due by March 30, 2007 — go to www.nccbh.org (Industry Events and Programs) for details.

The National Council for Community Behavioral Healthcare and other organizations offer several resources to assist your organization in making critical decisions about and implementing the Electronic Health Record.

The **37th Annual National Council Conference, March 26–28, 2007** at the MGM Grand, Las Vegas, offers robust learning sessions, featuring case studies and national experts, on various aspects of EHR implementation. Go to www.nccbh.org/vegas and look for EHR-related sessions in the Performance Improvement and Executive Leadership tracks.

Order a replay of the National Council Meet Me Call, *Where Do I Start in Implementing an Electronic Health Record*, presented by Dennis Morrison, PhD, President and CEO of Center for Behavioral Health and National Council Consultant and Grady L. Wilkinson, ACSW, President and CEO, Sacred Heart Rehabilitation Center, Inc. Order at www.nccbh.org (click on Services, then Meet Me Calls).

Learn from other providers' experiences — engage in dialogue with your peers through the National Council Member Listserve. Seek out best practices and post your questions. Go to www.nccbh.org (click on Services, then Member Listserve).

The National Council offers referrals to consultants with in-depth experience in helping behavioral health providers navigate the complex process of EHR installation and implementation. Consultants can help you make important decisions about technology solutions. To learn more, call **301.984.6200**.

The Mental Health Corporations of America and the Software and Technology Vendors Association paper, *Planning Your EHR System: Guidelines for Executive Management*, offers guidelines for the successful purchase, implementation, and ongoing development of EHR systems. Download at www.nccbh.org (See Links and Resources).

The National Council cosponsored and edited a special supplement published by UNI/CARE Systems, Inc, titled *Electronic Health Record Roadmap*. The supplement presents an overview of the EHR and brings together provider experiences and challenges in implementation. Download a PDF at www.nccbh.org (See Links and Resources).