

Responses to DMH Questions to HowardCenter re: COA Application

For Electronic Health Record

3/14/08

Questions Referencing Application Statements

Reference A: *On April 27, 2004 President Bush announced an executive order establishing the Office of the National Health Information Technology Coordinator (ONCHIT), which mandates a computerized health record within 10 years.*

Question A1: One of the results of ONCHIT was CCHIT, the certification body for EHR's. Please describe how your RFI process and vendor selection was influenced by CCHIT certification.

Although impending certification is required, currently there are no standards for behavioral health care and we did not focus on software certification in our RFI or vendor selection. Actually, we selected ADG, PsychConsult, in 1997. ADG is a member of the Software and Technology Vendors Association (SATVA). SATVA along with the Mental Health Corporation of America (MHCA) and the National Council for Community Behavioral Healthcare (NCCBH), are members of the Behavioral Health Treatment Standards Workgroup (BHTSW) established by the Substance Abuse and Mental Health Services Administration (SAMHSA). BHTSW meets monthly by conference call and semi-annually for two day in person meetings with the emphasis on the review and coordination of national efforts to promote widespread adoption of EHR and related standards for behavioral healthcare. HowardCenter's intention is to address both the certification and interoperability standards contractually with ADG. It is the opinion of HowardCenter that waiting until preliminary or even final behavioral health certification is available is making an expensive risk/benefit decision.

Reference B: *In our efforts to enhance clinical care, promote operational efficiency and satisfy federal mandates, HowardCenter has developed a project plan and budget related to the implementation of an EHR. The project plan, which will be completed over a two year period, is to utilize HC existing operating software (PsychConsult) to automate clinical workflow and produce electronic clinical documents.*

Question B1: What modules of PsychConsult are currently in use at HC? Please describe how the existing implementation will provide the enhanced functionality (e.g., does the project contemplate an upgrade or replacement of all software currently in place, purchase/implementation of additional modules, customization of existing or new modules, etc.).

Currently, the HowardCenter uses PsychConsult for demographic look up and to process billing transactions. Specifically, our Data Entry group keys from Intake paperwork the demographics, assignments, diagnosis, and insurance information.

Then services are interfaced from time capturing systems (web-based and off paper) through ADG's batch processor. Claims are created and payments processed (837 and 835), and AR management / billing functions are done with ADG software. State reporting (MSR, ADAP) is done from the PsychConsult database. Implementing an EHR through the use of PsychConsult Provider software will involve using the following modules that are part of the software but not currently used by HC: Call Center (for Crisis as well as Reception), Scheduling, Clinical Reception, Clinician Caseload Manager, Supervisor Case Manager, Treatment Plan, Clinical Documents, and Chart Management. Note that Clinical Document is a highly configurable toolset for Progress Notes, Assessments, Discharge Summaries, Referrals, and other documents. The project plan includes two non-ADG product integrations: TouchScripts from AllScripts for medication management, and external document scanning and image management (cost proposal from System Imaging, Inc. of Pittsburgh, PA.)

Reference C: The EHR will be consistent with VITL's Health Information Technology Plan; BISHCA's Health Resource Allocation Plan; the developing national standards for interoperability of electronic health information systems; does not significantly increase utilization or rates and does not substantially change the type, scope or volume of services. Once a Health Information Exchange Network is established, HowardCenter will be able to exchange health information with other health care providers, outside the HowardCenter system.

Question C1: How did the RFI and selection process address interoperability via VITL and national standards?

Please refer to our answer to Question A1. HowardCenter acknowledged the pending status of standards and the need to form a partnership with the EHR vendor to work toward local interoperability. Both of these issues will be addressed and managed contractually. Currently, both telephone and face-to-face meetings between ADG and VITL have occurred to better define and understand the functions and mechanics of the Vermont RHIO as it is being envisioned.

Question C2: How did the RFI address interoperability with any existing providers?

HowardCenter did not address interoperability in the RFI. The preferred means of addressing interoperability with existing providers is through the RHIO, which in Vermont is VITL. HowardCenter plans to approach interoperability in this way.

Question C3: Were the costs participating in a health information exchange (e.g., any subsequent interface development and maintenance) considered as part of this COA, and if not, how will they be addressed?

No, connectivity costs are not part of our project to automate clinical documents for the purpose of producing an EHR. Participating in an HIEN would be considered operating costs and will be addressed in the normal budgeting cycle process.

Reference D: *Most recently, HowardCenter issued a Request for Information (RFI) to selected vendors.*

Question D1: Can DMH see the RFI and responses?

Our RFI is attached, but given the proprietary and sensitive nature of the responses and the responder's connection to the State RFP process HowardCenter does not intend to share them at this time.

Reference E: *HowardCenter's EHR implementation will increase the availability and accessibility of developmental and mental health services by improving clinical efficiency. These efficiencies will reduce the amount of time clinicians spend producing manual documentation enabling them to see more patients, while significantly improving their care.*

Question E1: The literature suggests that EHR implementations result in an initial productivity loss until training is complete, bugs are worked out, staff become experienced using the new system, and processes align with the new model. What allowance has been made for this initial decline in productivity, and how long do you expect the transition period to take from net productivity loss to net gain?

The project plan allows for the consecutive implementation of programs in the use of the EHR as opposed to concurrent implementation. This will allow for more manageable training events through utilizing "super users" who will in turn be capable of training other users. Business interruption, if and when it occurs, will be covered in the overall budget contingency set aside for this purpose. Training is planned for four to five half day sessions per clinician, which should not result in significant productivity loss. (Please refer to the response to General Question 11)

Reference F: *Certainly, this will improve the service needs of the population we serve over time through the use of higher quality documentation; built in protocols and reminders; improved medication management; more efficient chart management and the use of clinical tools not available with paper based systems.*

Question F1: How will medication management be improved?

Improvements are expected in two categories – using TouchScripts features for e-prescribing, decision support, patient adherence, etc.; and by referencing TouchScripts data within PsychConsult clinical documents (notes, summaries, etc.)

Question F2: If there will be an interface between the EHR and a pharmacy solution to handle medication management data, please provide details including how costs were determined.

Askesis has interfaced TouchScripts at Western Psychiatric Institute and Clinics in Pittsburgh, and will make this code available to other customers looking for that interface.

Reference G: *HowardCenter and Fletcher Allen Health Care are formally discussing how both entities can better function as an integrated healthcare delivery system. Being partners in the functional area of EHR's and related information technologies is a strategic objective with many mutual benefits.*

Question G1: What agreements on standards for data interchange have been made with Fletcher Allen?

In our meetings with FAHC and VITL, we are planning to collaborate on an interoperability project that will allow us to exchange EHR data through EHIN queries. We have also had preliminary discussions with VITL related to a similar project with the Veterans Administration. HowardCenter will certainly defer to VITL for data exchange standards.

Reference H: *Certainly, it is important to remember that the project budget includes a business interruption contingency in anticipation of mitigating the risk of business interruption as a result of billing transaction slow down. There is also the assumption that there will be significant redeployment of staff and financial resources as the EHR becomes an integral component of our service delivery system.*

Question H1: What are the specific areas of business interruption that have been anticipated, and what are the estimated cost details?

The business interruption contingency is related to training release time anticipated for staff as it relates to their specific program area. There may also be minor billing transaction remediation that will need to occur during program go live. The overall allowance contingency for these items is estimated at the industry norm 25% of hard project costs.

Question H2: What are the anticipated or estimated impacts of staff redeployment resulting from the EHR? Specifically, please discuss how the increased Information Technology demands for training, change management, database management, help desk, application support, desktop support, report writing, and system administration have been evaluated and accounted for in the ongoing operational costs of the system.

Projecting redeployment as a result of the transition to an EHR from a paper based system is elusive at best. We anticipate increased operating costs in IT due to the need for around the clock support for the EHR in the way of help desk and field service. In addition, we realize that there will be efficiencies gained in Health information and Data Entry that will offset the increase in IT costs. Admission, transfer and discharge functionality will impact administrative support staff throughout the agency and their roles may change more dramatically. All redeployment costs will be evaluated during implementation and adjustments to our operating budget will occur as a result. Specific IT skill sets as identified in the question (training, change management, database management, help desk, application support, desktop support, report writing, and system administration) already exist in the IT Department of HowardCenter in the form of ten individuals (excluding Data Entry) with varied roles, skills, and responsibilities. These resources have been engaged over the course of the last ten years with EHR implementation on the strategic horizon.

General Questions

General Question 1: How have the costs of initial decreased staff productivity been estimated, and where are they reflected in this application?

There is a 25% business interruption contingency added to the overall project budget. This is based on industry norms and the identified training in the project plan.

General Question 2: Please provide a detailed breakdown of project costs included in Table 1, including:

- hardware and associated infrastructure;
- implementation services breakdown;
- scanning costs, types, and number of documents to be scanned;
- what disconnected database costs entail;
- business interruption contingency detail;
- Staffing costs for project management, user training, technical training, and ongoing system administration, database administration, programming, report writing, user support, and change management.

Please see Project Cost Detail Worksheet attached.

General Question 3: How many clinical notes/forms will be migrated to electronic versions?

A study conducted in late 1998 identified 361 forms used by HowardCenter. As that study noted and as we believe is still the case today, many of those forms are modifications on common datasets and can be standardized. The project budgets for a maximum of 100 new clinical documents to be created in PsychConsult.

General Question 4: How many and what kinds of staff (e.g., MD, nurse, clinician, clerical) will use the EHR? For what function will each of these disciplines use the system.

Generally speaking:

- **Medical Staff will use the Caseload Manger to see and approve treatment plans, complete progress notes, approve summaries, etc. They will use TouchScripts for medication management. They will use Reporting for numerous purposes.**
- **Clinical Staff will use the Caseload Manager, Treatment Planning, Clinical Documents, and Reporting to support their workflows and clinical documentation requirements.**
- **Supervisors will use the same tools as clinicians, with the view toward exception handling and quality assurance.**
- **Crisis Services will use Call Center in addition to clinician tools.**
- **Administrative staff in programs will use Intake, Reception, Scheduling, and Reporting.**
- **Billing staff will use Intake, Billing / AR and Reporting.**
- **Health Information staff will use Intake, Chart Management, Scanning, and Reporting**

General Question 5: What is the anticipated impact of the EHR and associated software, hardware, and networking on your enterprise IT architecture?

The HowardCenter IT infrastructure already contains the underlying components of SQL servers, Citrix access, SQL Reporting Services, and the general Microsoft networking environment, but expanding the use of the PsychConsult application set will require expanding Citrix, a larger SQL server, and enhanced backup technology. These are budgeted in the project. Further, the disconnected database solution for remote users with no connectivity will be a new technology to HC.

General Question 6: What is the timetable for the project (e.g., high level Gantt chart of key tasks)?

The initial project plan used for project budgeting purposes contained 248 tasks that result in an overall duration of 415 days. Subsequent conversations about the project have identified advantages to sequential introduction to clinical programs rather than a more concurrent implementation. We are in the process now of reformulating the final project plan, but expect the duration to be approximately two full years.

General Question 7: This application appears to address costs for project implementation only. What are the estimated ongoing operational costs such as staffing and change management that is associated with maintaining and updating the EHR system?

Implementation of the EHR will both decrease and increase operating costs. HowardCenter plans to keep the overall effect neutral to the operating budget by balancing the following effects:

- **Program administrative staff will be more involved in intake, scheduling, and authorization processes.**
- **Clinicians will have more time for billable services, and scheduling efficiency is expected to improve.**
- **Health Information will save time in paper handling and audit functions, but assume new tasks related to scanning.**
- **Data Entry will save time in entry functions, but increase exception handling and training time.**
- **Information Services will require greater Help Desk coverage, application training, and programming time related to clinical documents and reporting.**
- **AR days, billing denials, and service paybacks are expected to improve.**
- **Costs related to document storage, retrieval, and destruction are expected to level off / stop increasing.**

General Question 8: Your application states that HowardCenter plans to raise the entire \$1.7 million for this EHR through contributions. How will the agency fund the project if it fails to generate the entire amount through contributions?

HowardCenter has a history of positive results from Capital Campaign fund raising efforts. We fully expect to be successful in these efforts as well. The preliminary feasibility study conducted in this regard indicates attainment of our stated goal.

General Question 9: The entire \$1.7 million of anticipated contributions does not appear to be reflected in your financial statements. The income statement for "Project only" indicates

approximately \$1.2 million in Local/Other funding, which we assume is the amount of contributions during the four year span. Where is the other \$500,000? Will contributions continue to be collected after the system has been installed? Please clarify.

Contributions will continue to be collected after the system has been installed. The remaining \$500,000.00 will be considered a Temporarily Restricted Net Asset and will be recognized as revenue to offset depreciation expense related to this project in years 2012, 2013 and 2014.

General Question 10: Please describe in detail the proposed system's clinical decision support functionality. What features will be available to clinicians for the support of diagnosis, treatment, medication management and other clinical functions?

PsychConsult's clinical decision support capabilities come from many aspects of the system:

- **Patient Symptom Inventory – symptoms can be pre-defined, group by program, and associated with diagnoses. This helps to structure this information.**
- **Assessments (risk assessment, GAF, CBCL, etc.) – The system has many standard assessment tools (and others can be added) whereby the assessment information or results can be referenced by other documents and processes.**
- **Problem Lists and Goals in Treatment Planning – Content in the treatment plan creation and review process can be structured so as to consider short-lists or standard elements.**
- **Treatment Plan demographics and goals to Progress Note – There is auto-entry of standard information from the treatment plan into the progress note, so that emphasis (time) can be place on observations / descriptive progress.**
- **Automated Summaries – Information from other documents (treatment plans, notes, assessments, etc.) can auto-populate summary document such as a discharge summary so as to standardize communication of referral / discharge info.**
- **Med Note – The medication check progress note references the prior med check note and saves time, focuses attention on changes.**
- **TouchScripts – AllScripts product is industry leader in e-prescribing, with drug interactions / allergy / food check and patient adherence indicators.**
- **Creativity w/ Documents – PsychConsult documents can be modified and created to support other, not yet conceived, data and process associates to support clinical decision-making.**
- **Reports – Data is stored in M/S SQL database and can be reported against for clinical / programmatic decision-making and quality assurance purposes.**

Question 11: Please discuss the training you will employ for clinical staff to use this system efficiently. Please quantify the learning curve for clinical staff and describe any challenges you may encounter.

The basic training model is to provide 4 to 5 half-day sessions per staff for them to learn the new processes. Supervisors (who are expected to perform some training and post live support) would receive 4-5 full day sessions. Delivery of training is to be by program, sequentially implementing in smaller groups, with training split 2/3 up front and 1/3 after live. Both supervisors and IT training staff will provide hand-on training and post-live support.

We expect challenges related to staff adoption of new procedures, using the computer, and change in general. To address this, HowardCenter plans to include into its clinical document design process and its user scripting process those individuals that exert both formal and informal leadership within the organization. Further, through sequential implementation, more resistant or entrenched groups can be staged later in the project implementation sequence, while all groups can get more specific attention.