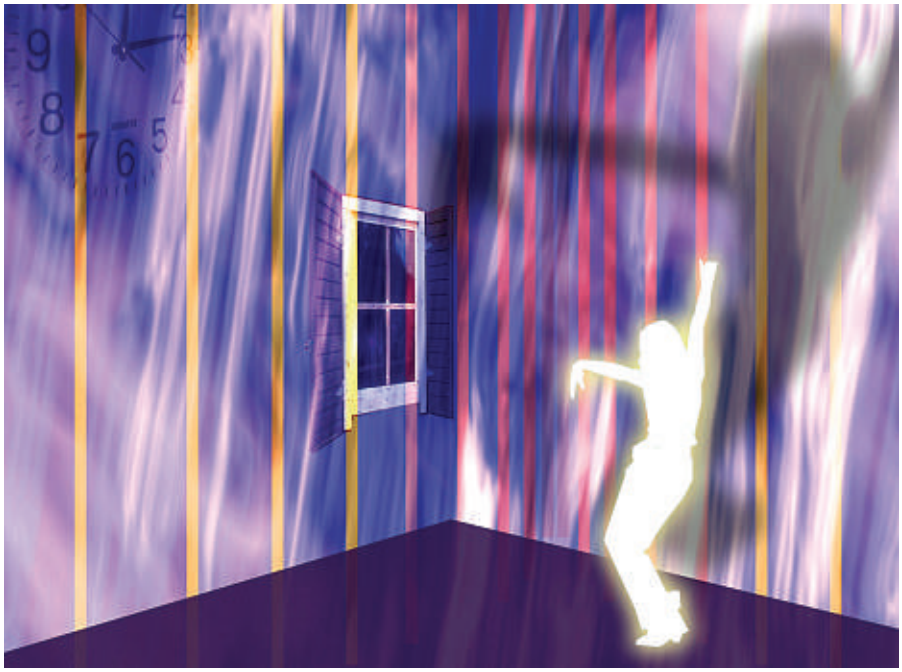
Bringing new rhythms to care

How one provider went from the paper shuffle to the "electronic slide" **BY MATT DEBEER AND JASON WILLIAMS, PSYD**

Childrens Hospital Los Angeles (CHLA) sees more than 2,500 patients per year in its mental health department. Each year, the department recruits 20 interns and fellows for a one-year program in which they provide clinical services to the public under a senior clinician's supervision. Despite employing interns who are new to therapy, as well as hospital procedures, and the constant turnover of new interns each year, the mental health department is consistently profitable. Even more remarkable, last year CHLA received a JCAHO rating of 98 out of 100.

But it wasn't always this way: The daily rhythm was that of a complicated paper shuffle.



The Problem

Clinicians are required to provide documentation each time they see patients. Prior to implementing a clinical management system, documentation involved a cumbersome paper shuffle back and forth between clinicians and supervisors, and ultimately the billing department. It was a tedious process to determine whether a report had ever been written, approved, or submitted for billing. As a result, clinical notes were difficult to locate and billing often was delayed. In addition, exchanging paper documents increased the risk of lost reports or HIPAA violations.

Furthermore, no effective way to measure the long-term productivity of interns and other staff members existed. Productivity was measured with weekly status reports that provided neither long-term trends nor comparisons with other employees. The paper-based system also enabled employees to put off writing documentation until the end of the month, which caused an unnecessary burden on front-office staff.

The Solution

CHLA realized it needed an electronic clinical management system to streamline its processes. The first step was to identify the requirements of such a system. The system needed to provide functions common to all clinics, such as the ability to record patient demographics and medications, schedule appointments, and produce invoices for services. CHLA also needed a way to ensure that clinical documentation written by interns could not be admitted into the clinical record without supervisor approval. Finally, the system needed to handle multiple sets of billing codes. Most CHLA mental health services are reimbursed by the Los Angeles County Department of Mental Health, which uses a unique set of billing codes. In addition, a new set of CPT codes was introduced in 2002 to enable providers to bill for mental health services with the coding system used for medical billing. CHLA's system needed to accommodate both standards, as well as provide a way to create clinical notes specific to each payer.

CHLA faced a build-versus-buy decision. For common needs such as scheduling and capturing patient data, many off-the-shelf systems are available, but CHLA's unique needs meant a custom system probably would be required. The problem with this approach is that custom software development is notoriously expensive and prone to delays.

CHLA's solution was a hybrid approach: using an off-the-shelf system to save costs but customizing it for its needs. CHLA chose Exym, Inc.'s Activity Tracking System.

The Details

CHLA began by organizing its patients into different clinic types. This enabled

them to capture patient data unique to each clinic in addition to common fields such as date of birth. Next, they created billing groups. A billing group consists of a set of standardized descriptions of services with associated billing codes, rates, and clinical notes. When adding scheduled services to a patient record, the clinician selects from the standardized list of services associated with that patient type. The system automatically records the billing code and rate, and creates a new clinical note for the service. (It creates a blank note record with date of service, service description, patient name, therapeutic goals, diagnosis, and default text already filled in. When a clinician is ready to document the service, he/she just clicks a link and fills in the blanks.) The advantage to this approach is that it saves the clinician from having to worry about coding, thus reducing errors, and tightly couples the documentation with the service. Once recorded, a service cannot be billed until the clinical note is completed and approved by a supervisor, thus ensuring that all services are documented, and that all documentation receives a quality-control check.

The same system used to record billing for clinical services also is used for scheduling appointments. For example, prior to an appointment, an entry is made in the system that describes the upcoming service along with its associated billing codes, rates, and the clinical note linked to it. All of this information is entered by simply selecting an activity from a list of predefined choices. Once selected, the activity will show up on a report used by the front office to see upcoming appointments. Once the appointment is completed and documented, it no longer appears on the pending appointments list and instead appears on the list of activities to be billed. The advantage of this approach is that by having a centralized schedule, the front-office staff can anticipate problems prior to a patient's arrival, such as assuring that preapproval has been established.

A key part of this process is that staff members see only the information relevant to their roles. Front-office personnel can see that patient X is coming in on Tuesday, but they cannot see the clinical note that documents what transpired during Tuesday's session. CHLA estimates that prior to implementing the new system, paper documentation changed hands four or five times before it reached the front desk for billing. Now only the final document needs to be printed, and that can be done separately from the front office.

Also tied to the individual services is the therapy room in which the service will take place. Because all 200 members of the mental health staff use this centralized system, an individual clinician can see that a given therapy room is open at a certain date and time and reserve it in the same place in the system he/she recorded the therapy appointment. As a result, clinicians no longer have to walk down the hall and use a sign-up sheet to reserve a room.

When scheduling an activity for someone else, the system user can quickly see a calendar of that person's availability based on the other activities scheduled for him/her. This is particularly useful when scheduling group sessions that involve multiple therapists or notifying others of blocks of time that are unavailable for seeing clients.

Another key element of this system is the big-picture view. CHLA supervisors can review services from initial intake to diagnostic impressions, treatment planning, and goals for the client. They can quickly review in one place all interns' notes awaiting approval, with the ability to comment on the notes and return them to the intern for further edits—all done electronically.

The ability to transform scheduled services into billable activities means that management easily can spot trends and measure performance. For example, supervisors can set a billing target for an intern, then measure his/her actual performance against the target. This enables management to identify clinicians who are less productive so that obstacles to productivity can be identified and adjusted. The system also can answer questions such as, "What is the average number of sessions per patient?" and, "Which times of the year are busier than others?" CHLA was even able to see that a strike by Los Angeles bus drivers increased the no-show rate by 13%.

The Results

CHLA's mental health department reduced the time it took to process documentation, from patient visit through billing for that visit, from as much as two weeks to as little as 24 hours. In addition, billing is now processed daily, avoiding a stack of paperwork to process at month's end, and billing code errors are virtually nonexistent.

The new system has improved the quality of care, as well. For example, waiting lists are better managed by simply printing weekly reports sorted to show those patients who have been waiting longest at the top of the list. Supervision of trainee documentation is an integral and seamless part of the system. Information about a patient is easily accessible from one place, whether it's treatment goals, DSM-IV descriptions, patient contact information, or medical records. (The information a user can view or modify is based on a user's role within the system; a person without a role cannot access any of the data.) In other words, the system enables clinicians to spend less time on paperwork and more time focusing on patient needs. **BHM**

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