

**PAPERWORK REDUCTION IN THE  
ARIZONA BEHAVIORAL HEALTH SYSTEM**

**A Report of the  
Paperwork Reduction Committee**

**To**

**Arizona Department of Health Services  
Division of Behavioral Health Services**

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## Executive Summary

The Paperwork Reduction Initiative was launched by the Arizona Division of Behavioral Health Services (DBHS) to examine the impact of administrative paperwork within the publicly funded behavioral health system. Led by a workgroup composed of state, provider, Regional Behavioral Health Authorities (RBHA) and community stakeholders, the Initiative conducted detailed data collection through review of documents and forms and stakeholder interviews. Through this in-depth process, the workgroup also identified areas where streamlining and simplification would potentially be of benefit, even though paperwork concerns were not specifically at the root of these areas. These recommendations are also included in this report for consideration.

Key recommendations of the project follow:

### Leadership and Sustainability

- It is recommended that DBHS leadership develop a culture of “paperwork reduction” at all levels of the behavioral health system. When new processes, initiatives, reports and policies are considered or when existing ones are reevaluated the “paperwork burden” on the system should be a major consideration along with the question, “Can this be done more efficiently electronically?”
- Agency respondents also suggested that DBHS improve its oversight of administrative and paperwork requirements implemented by RBHAs as part of their annual review process, including methods to assess and eliminate barriers to using electronic data collection and submission.
- It is recommended that DBHS leadership adopt the major recommendations made in this report, include them in the Department strategic plan and make a public declaration of support to the Behavioral Health community.
- It is recommended that DBHS assign the responsibility to a key staff member of carrying out report recommendations, including the monitoring and sustainability functions as outlined, and lead DBHS and the behavioral health system toward greater emphasis on outcomes and less on process.

- It is recommended that DBHS hire a staff person or consultant to lead DBHS in development of a total electronic data reporting and clinical record system plan. This person must be very knowledgeable and current on the latest national trends. Leadership and communication skills are also critical in this area to facilitate DBHS, RBHAs, Providers and Consumer involvement in developing and implementing a statewide approach.
- DBHS should name a responsible party at DBHS and each RBHA to respond to questions about policies to reduce answer-shopping and multiple interpretations of policy content.
- Each RBHAs should implement a Sustainability Committee comprised of RBHA and provider representatives to review forms, reports, data, etc., prior to implementation. Establish a procedure to review and approve new forms and reports – including a review of data and reports currently being collected – before creating a new requirement.
- DBHS should centralize a process for policy/procedure changes on an established schedule.
- Establish a Committee of RBHA, Provider and DBHS representatives for Sustainability. They will approve all new reports, data elements, etc.

#### Overarching Themes

- Consider the use of clinical software libraries in future system development.
- Consider dropping a variety of current process measures as a form of accountability and utilize the Tracker-Tracer method of process review.
- Clarify audit standards at the beginning of the year so constituents know, and can prepare for, what will be measured. Chart compliance will improve if providers know what auditors will look for in future audits.
- Coordinate and streamline audits by multiple agencies (i.e., RBHAs, OBHL and DBHS).
- DBHS should focus on building a system of accountability based on outcomes.
- Review best practices in monitoring and implement more real time, real world monitoring methods that allow agencies and staff to focus on improving areas that matter most to clients rather than submitting reports.

- Requiring providers to post the same required notices (e.g., client rights) on different letterhead within the same facility is redundant and should not be required.
- DBHS should take the lead in fostering the development of electronic data to replace/reduce paper.

#### Eligibility

- DBHS is encouraged to develop a Master Signature Sheet or, more preferably, an electronic file with verification, to reduce the number of forms consumers and families must sign at admission. Further, DBHS and OBHL should work together on defining what needs to be signed with an effort at reducing the number of forms while not compromising consumer rights.
- Establish the same standard for RBHA/providers as for Health Plans concerning eligibility. That is, require behavioral health agencies to complete the preliminary financial screening process only, and establish a fuller eligibility function at the DBHS level.
- Establish user-friendly eligibility tools on the DBHS website, similar to MyAHCCCS.com, the AHCCCS 1-800 number, links to the DES website, on-line applications and instructions.
- Information in Provider Manual 3.1 is very complex and requires highly trained benefit specialists to decipher. DBHS should review eligibility policies, procedures and requirements on the AHCCCS website which are very simple and easy to follow.
- Consider whether TXIX/TXXI screening and referral report is still useful or necessary. Can this manual, process-focused report be replaced with a monthly indicator (e.g., percent of enrollments that are TXIX) based on CIS database enrollment?
- DBHS and the RBHAs should work together in the design and implementation of a meaningful sliding fee scale process.

#### Children's System

- Establish a service code or modifier for Case Management when the service is actually a CFT meeting. This would allow the tracking of CFT meeting time without a separate reporting system.
- Identify what data and reports are meaningful and necessary for CFT processes. Use electronic data whenever possible. If it is already captured in CIS or another report, don't ask for it again.

- Develop a small set of standard reports that focus on outcomes and family progress, rather than the broader CFT process, and require these statewide.
- Clarify CFT expectations for brief or lower needs children and reduce the required paperwork and monitoring processes accordingly.
- Clarify the purpose of the SNCD, service plan, and CFT progress note. OBHL requires the same information in the assessment, treatment plan, and medical record updates.
- Some staff currently maintain both the treatment plan and the Strengths Needs Cultural Discovery (SNCD) in addition to the CFT assessments and must cut and paste between the documents in order to meet OBHL, RBHA and DBHS audit requirements.

#### Annual Children's Plan

- This report should avoid merely repeating information from other reports. It should focus on progress in the system.

#### Inter-RBHA Transfer Process

- Consider developing a policy change that would allow a single consistent Release of Information for the entire state that informs consumers that their records can follow them without obtaining new signatures (as allowed by law).
- Convene a workgroup of RBHA, provider, and DBHS staff to review CO 1.1 (Inter-RBHA Coordination) with an eye to what accomplishes the goal of a seamless inter-RBHA transfer without micro-managing the process. Consider whether the 7 day/14 day timeframes are realistic. Provide ample opportunities and venues for clients to lodge complaints or provide feedback about the transfer process.
- Consider having DBHS conduct disenrollment/re-enrollment functions for transitioning persons. This would ensure continuity of care and allow providers to bill for the time needed to successfully transition – even if the transition is “after-the-fact.”

#### Notices and Appeals

- Use a single form and timeline for all notices and/or appeals.
- Combine policies and Provider Manual sections on notices and those on grievance and appeals if possible. There are too many sets of instructions for staff to understand and consistently apply.
- Establish a method for electronic submission of appeals information.

- Review other states' implementation of notice and appeal requirements to determine whether simpler, more streamlined methods are possible.
- Use a form maker to design the actual notice templates. Language and formatting of the notices and appeals are excessively legal and not meaningful to consumers. Use color and graphics to make the documents "friendly."
- Host several consumer/family focus groups to gather input on the current notice and appeals process. Make the Notice and Appeal process much more "customer friendly."

#### Advance Directives

- Create a database to house Advance Directives.
- Review the Advance Directive process and make it simple, understandable, and meaningful.
- Consider eliminating the requirement to send annual information regarding advance directives to all enrolled persons. Instead, post information and education in provider lobbies.

#### Incident/Accident/Death and Seclusion/Restraint Reports

- It is recommended that the multiple sets of Incident/Accident/Death and Seclusion/Restraint directives be reviewed, consolidated and condensed where possible.
- It is recommended that reports be transmitted via secured electronic file.
- Develop a secure file method for electronic transmission, including a web portal for direct entry into DBHS databases.

#### Annual and Quarterly Network Plan and Inventory

- It is recommended that changes to the Network Inventory required by DBHS be synchronized to the fiscal year, not the inventory report date.
- The Network Inventory should be reviewed in terms of a) who uses the information collected? b) is the information available from other sources and existing databases? and c) can the information be streamlined or made electronic?

#### Corrective Action Plans

- It is recommended that DBHS re-evaluate the Corrective Action Process with input from RBHAs and providers. Emphasis should be placed on streamlining and clarifying the process. A single DBHS repository for corrective actions should be established because corrective actions

required by different areas of DBHS increase the likelihood of overlapping, being in conflict with one another, or being duplicative. A central registry should be developed to eliminate these problems.

#### Quick Fixes

- A variety of “quick fixes” to help reduce paperwork are relatively easy to implement. They are found in the section, Quick Fixes.

#### Opportunity: Total Electronic Data Reporting and Electronic Medical Records

- DBHS should take the lead in development of electronic data submission and electronic medical record development by hiring an expert in the field.
- Statewide electronic data submission and electronic medical record development should be underway within one year with systems in place by 2013.
- The cost to implement, maintain and update computer systems is a major issue. This must be addressed.
- Data fields should be standardized, not forms or paper.
- Develop a web-based record with security code for individual consumers.
- Computer systems must have ability to scan in hospital records, past evaluations, school records, and medical care that can be maintained as part of the consumer’s behavioral health record.
- Computer systems must have electronic signature capability (R9-20-208 does not require an individual signature for each item)
- Develop computer kiosks for provider wait rooms so that consumers can complete forms, participate in consumer health education, rate satisfaction with services, respond to outcome measures, etc.
- Include a coordinated Technical Assistance component when implementing and maintaining electronic data systems.

## **Project Overview**

The purpose of this report is to support more effective, efficient, and customer-friendly services and provider agency environments by streamlining and reducing paperwork in the behavioral health system.

### **Introduction: Healthcare Workers are Drowning in Paperwork**

Significant and excessive amounts of paperwork are cited as barriers to workforce retention, staff satisfaction, and quality of care within the public behavioral health system. The Paperwork Reduction Initiative was launched by the Division of Behavioral Health Services (DBHS) to examine the impact of administrative paperwork within the Arizona behavioral health system. Led by a workgroup of state, provider, Regional Behavioral Health Authority (RBHA) and community stakeholders, the Initiative conducted detailed data collection by reviewing existing documents and forms, analyzing contract deliverables, and interviewing stakeholders. This report describes these processes and proposes opportunities and recommendations for paperwork reduction, suggests the need for a sustainability factor to avoid future “paperwork creep,” and recommends a shift in accountability from measuring processes to achieving outcomes. Significantly, the report also advocates for the development of automated methods to reduce paperwork, in terms of the systemic development of electronic data report submission and utilization of electronic medical records. See Appendix 2 for an overview. Comments from the field are included in this report to provide a flavor of the impact of paperwork on the field. While the report is a critical analysis, the intent is to provide constructive and realistic recommendations to improve Arizona’s behavioral health system of care.

In this report, recommendations from the text (denoted in ***Bold Italicized*** type) are reported in the Executive Summary. The terms “consumer” or “client” are used interchangeably and generally refer to the recipient of behavioral health services and/or his or her family, significant other, or designated person.

## **Method**

### **On-Line Provider Survey**

An on-line survey was developed and posted to the ADHS/DBHS website in May 2007 with a link to statewide and regional provider list serves. Respondents (N=58) were asked to rate the top five most burdensome reports, forms or processes, and to provide recommendations for how these requirements could be modified or merged to reduce administrative workload at different levels of the system.

### **Provider Interviews and Walk-Throughs**

Beginning in June 2007, Committee members conducted external stakeholder interviews, using a standardized protocol, at behavioral health provider agencies, community services agencies and consumer-operated programs, and Regional Behavioral Health Authorities across the state. The protocol specified participation by executive, mid-management and front-line clinical staff and generally lasted 4-5 hours. In many cases, Committee members also conducted a “walk through” of the agency intake or service episode process in order to observe the administrative steps, forms and reports generated at the front-line of service delivery. Information was gathered to identify areas for streamlining and simplifying processes while reducing paperwork- and data collection-redundancies. In total, 20 agency sites participated in the walk-through process. See Attachment 1 for a list of agency participants. Areas or processes identified as most burdensome or duplicative were then prioritized for a more detailed review of relevant rules, requirements and policies.

## **Rules, Policy Manuals and Provider Manual Reviews.**

Using feedback from the provider walk-throughs, Committee members identified key areas in administrative and regulatory requirements contained in the primary rules packages and ADHS and RBHA provider guidance manuals affecting behavioral health services. Consistency between various requirements and the number of required forms and reports were a specific area of review. Topical areas included: client rights, notice and grievance and appeals; quality management and compliance audits; clinical operations, including assessment, crisis plans, Child and Family Team (CFT) practice and records documentation standards; and various network and financial reports affecting behavioral health services. Table 1 lists the documents and manuals reviewed.

**Table 1. Documents and Manuals Reviewed**

<b>Materials Reviewed</b>
<ul style="list-style-type: none"><li>• <b>ADHS/DBHS Policy and Procedures Manual</b></li><li>• <b>ADHS/DBHS Provider Manual and RBHA-specific Provider Manuals</b></li><li>• <b>Board of Behavioral Health Examiners Administrative Rules</b></li><li>• <b>ADHS Behavioral Health Licensing Rules</b></li><li>• <b>AHCCCS and ADHS Contract Deliverables</b></li><li>• <b>Administrative Review, Independent Case Review and provider monitoring audit tools and plans of correction</b></li><li>• <b>Intake paperwork, including AHCCCS eligibility screening and application process</b></li></ul>

### **Review of Contract Deliverables**

The AHCCCS/ADHS and ADHS/RBHA contracts were analyzed and compared to identify contract deliverables and reporting processes that might be reduced, eliminated or converted to electronic media.

## **Review of Intake Paperwork**

A subcommittee compiled and analyzed forms and documents required at intake to the behavioral health system. This material will be presented to ADHS under separate report.

## **Results, Discussion and Recommendations**

Paperwork is alive and well in Arizona's public behavioral health system. As noted by one survey respondent, "We have created a system of managing forms, not clients." In this section of the report, we summarize the concerns that contribute to the greatest paperwork burden or cause the *greatest* confusion throughout the system, rather than provide an exhaustive list of all forms and processes considered burdensome or duplicative. The results are discussed and recommendations for change are included, but the recommendations vary in complexity. Some are easily implemented (i.e., quick fixes), while others require a more focused workgroup to address, develop and implement (e.g., electronic data reporting). We include recommendations for sustaining a lower level of paperwork within the system over time. It should be noted that in responding to the survey and on-site interviews, respondents repeatedly stated that they were grateful to be asked for feedback and were hopeful that their participation would result in actions that influence the volume of paperwork in the system.

## **Overarching Themes**

Common, overarching themes emerged from data collection and analysis that cut across all of the specific areas identified as opportunities for improvement. First and most significant, relevant to a viable, satisfied workforce, clinicians expressed feeling overwhelmed by the sheer volume of written guidelines directing care and the frequent

changes in forms and policies. Clinical staff, in particular, voiced concern that the system does not trust or respect them. “Therapists feel that they are ‘punished’ when they make a mistake,” said one clinical supervisor. In general, they experience the detailing of processes and reports as micro-management and feel that staff satisfaction would improve if clinicians had greater autonomy in their practice and more time to see clients and deliver services. “The perception in the system is that quality of work is determined by documentation and paperwork productivity,” says one clinician. “This creates a dilemma for all direct care staff who have a passion to work with clients but are too burdened with documentation to provide covered services.”

At the same time, providers recognize the need to extend oversight processes and accountability to less-experienced Behavioral Health Technicians. This oversight process need not be so paper intensive, however, as electronic technology (i.e., clinical libraries) now has the capacity to assist new employees, trainees and lower level staff in conducting effective clinical assessments and exercising good clinical judgment, according to Leipold, 2007. ***Therefore, it is recommended that DBHS consider the use of clinical software libraries in its future system development.***

Another overarching theme addressed the current focus on measuring process rather than outcomes. Examples of process measurement included Out-of-State Placement Reports, the large number of forms and measurements for Child and Family Team practice, the TXIX Screening Report, the Administrative Review, and Corrective Action Plans. It was noted that process measurement is time consuming and does not take into account or reflect the quality of services or outcomes for consumers and families. One Site Manager said that he would like to see “process reduction.” Others

referred to “process simplification.” The point is that it is burdensome to staff to provide needed services to consumers due to required policies and processes. He asks, “measure us on what we do for our consumers.” The Corrective Action Plan (CAP) process, in particular, was viewed as rigid and paper intensive. There was also noted concern about “not receiving feedback from corrective actions or receiving it so time delayed that it isn’t actionable.” A more promising method than the hundreds of process measures currently in place, because it is may be more relevant to quality care and outcome, is the **tracker-tracer method**, used by the Joint Commission, which follows an individual through an episode of care or over a period of time to assess the quality of the system’s response. ***It is recommended that DBHS consider dropping a variety of process measures as a form of accountability and utilize the Tracker-Tracer method of process review. In addition, the DBHS should focus more on building a system of accountability based on outcomes.***

The Administrative Review, already mentioned as a measure of process, is challenging to RBHA staff who say there are no established benchmarks or standards until the end of the contract year. (2007 was a pleasant exception when sub standards were made available for the first time during the fall). Typically, when finally provided, standards result in new forms just to document compliance with the standards (e.g., advance directives). Even then, however, standards may not be judged in a consistent manner between DBHS and OBHL. RBHA staff tends to believe that the Administrative Review’s emphasis on process measurement should shift to the measurement of outcomes. In addition, the following recommendations relate to the Administrative Review, all audits and process-oriented measures:

- **Clarify standards at the beginning of the year so constituents know, and can prepare for, what will be measured. Chart compliance will improve if providers know what auditors will look for in future audits.**
- **Coordinate and streamline audits by multiple agencies (i.e., RBHAs, OBHL and DBHS).**
- **DBHS should focus on building a system of accountability based on outcomes.**

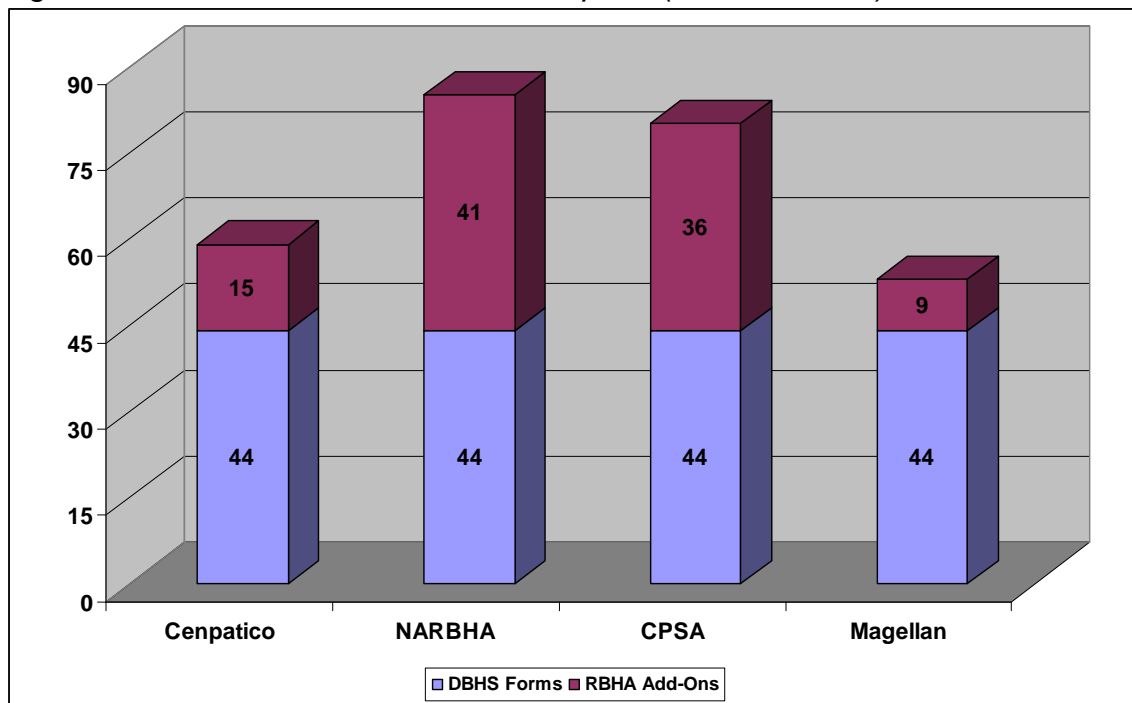
Still another overarching theme included the suggestion for on-site observational monitoring and a stronger focus on capturing the consumer/family point of view. As an example, one respondent pointed to the difference between results measured by the Internal Case Review (ICR) and RBHA audits (e.g. symptomatic and functional improvements) and direct consumer feedback on the annual Consumer Survey. This respondent wondered if we are measuring the right things: while the ICR record review shows evidence of improvement, consumer feedback scores the system much lower on improved outcomes. In all likelihood, different perspectives (e.g., chart review versus consumer feedback) may realistically lead to different results. Still, several respondents urged DBHS and the RBHAs to ***undertake a review of best practices in monitoring and implementing more real-time, real-world measurement methods that allow agencies and staff to focus on improving areas that matter most to consumers rather than submitting reports.***

Another theme focused on layering of forms, reports, notices and requirements by various levels of the system and intermediary administrative entities. A striking example of administrative layering cited by several agencies is the requirement for posting client rights and notices of confidentiality. These postings are required by behavioral health licensure (R9-20), HIPAA and administrative rules for persons with

SMI (R9-21). RBHA and provider staff interviewed stated that they were directed to post all notices at each level of the system to ensure the various levels “owned” the requirements. In many agencies visited, the same notices were repeated on the letterhead of DHS, the RBHA and the provider agency and covered entire walls in the reception area. ***Posting the same notice on different letterhead within the same facility is redundant and should not be required.***

Participants commended DBHS’ efforts to incorporate requirements in Behavioral Health Licensure rules and the Arizona Health Care Cost Containment System (AHCCCS) contract into a single set of service specifications (i.e., the Covered Services Guide). However, the Provider Manual, in particular, was cited as the source of multiple layers of forms and instructions, depending on the particular RBHA or service area. The DBHS Provider Manual includes 71 different attachments -- not including Spanish language versions -- of which 44 are forms and report templates. Each RBHA adds additional forms, report templates and attachments based on local system management needs. Figure 1 compares the total number of the forms added to the DBHS requirements by each RBHA.

Figure 1 *Provider Manual Forms and Reports (as of 10.24.07)*



Respondents noted that each additional funding silo, office or program initiative creates a new set of forms and reporting requirements (e.g. HIV activity reports, quarterly staffing/prescriber reports, children’s case manager rosters, clinical liaison rosters) as well as forms created in response to Corrective Action Plans. The RBHAs urged both DBHS and RBHAs to utilize existing data prior to implementing new forms and processes. “Many versions of the same data or report are already available just with slightly different formats or ways of asking the question,” says one agency CEO. Participants also felt it was important for DBHS and the RBHAs to talk prior to implementing new forms, reports and requirements. This relates to the sustainability factor referred to earlier in this report to help prevent “paperwork creep.” **Several respondents suggested that DBHS and RBHA staff establish a committee process**

***to review and approve new forms and reports -- including a review of data and reports currently being collected -- before creating a new requirement.***

We received several examples of what was believed to be excessive paperwork burdens that could be handled better electronically. For instance, agencies contracted with one RBHA listed several manual staffing logs that are submitted to the RBHA on a daily or weekly basis (e.g., direct care staff add/change form, Clinical Liaison/Treatment Team/CFT Update Form). Redundantly, in this same region, 834-enrollment and demographic submissions are reported in both paper *and* electronic formats. In another RBHA area, agency staff are required to submit special reports on crisis utilization established as the result of a 2003 DBHS corrective action requirement that were never discontinued even after the problem was long resolved. Still other respondents described incidents of multiple requests for the same report or information from different areas of DBHS and the RBHAs. In some cases, the information already existed in another report or within the CIS computer system. Finally, agencies required to fax reports to one RBHA consistently complained of having to fax the same report multiple times until the report finally found itself in the hands of the intended receiver. Clearly, faxing does not appear to be an efficient means of report or data submission. Each of these examples lends itself well to electronic data collection and submission as a means to reduce excessive paperwork burdens. ***DBHS is encouraged to take the lead in fostering the development of electronic data to replace/reduce paper, a theme we further address later in this report.***

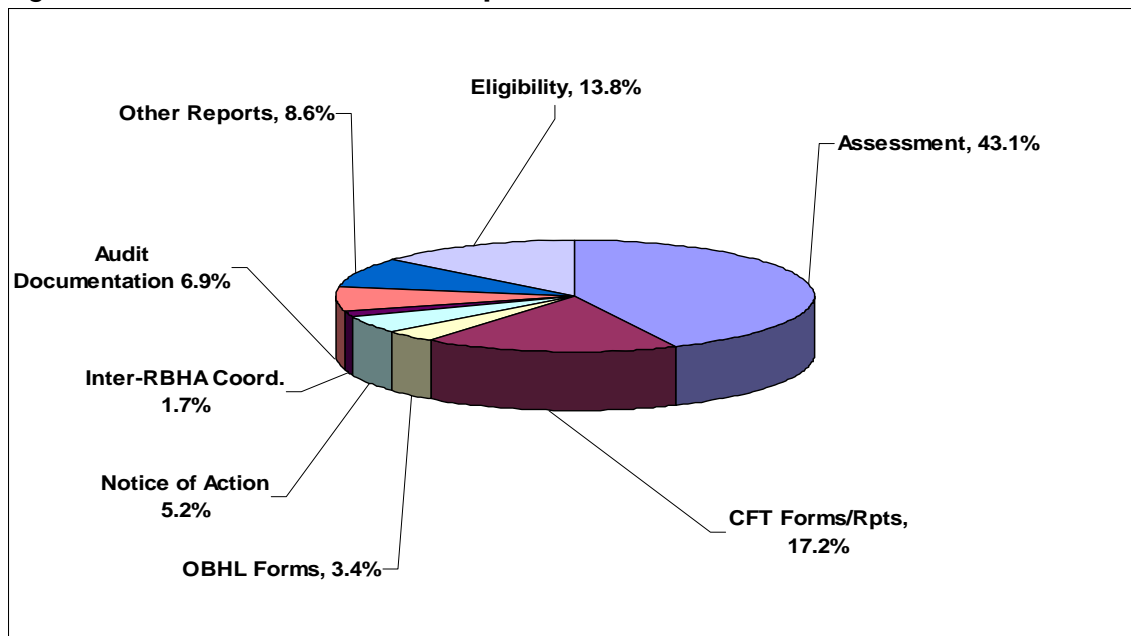
A final overarching theme was the discharge process itself. It was consistently mentioned during interviews as an overly burdensome process. The additional

paperwork involved when a behavioral health client passes away was specifically mentioned, with providers noting that many of the references in the forms are not relevant in a situation involving death. Also mentioned was the requirement of checking AHCCCS eligibility of a deceased member or when they are disenrolled from services. Finally, the Outreach and Reengagement process when required at disenrollment was mentioned as a particularly burdensome.

### **The Big Three**

Three key general areas were consistently cited in the provider survey and walk-through process as being the most burdensome, duplicative and time-consuming: (1) the Core Assessment and intake process; (2) the application process for AHCCCS eligibility; and (3) CFT forms and processes. Together, these areas accounted for 74% of the “most burdensome” reports/processes cited in the on-line provider survey. The Big Three are considered issues where DBHS should establish a more focused, short-term workgroup to analyze relevant factors, propose solutions and establish an actionable plan for resolving or reducing the paperwork burden. Figure 2 presents the most frequently noted reports and processes deemed to be burdensome to the system and the frequency they were mentioned. In this section, we detail the “Big Three,” to which we now turn.

Figure 2. **Most Burdensome' Reports and Processes**



Note: Paperwork Reduction On-Line Survey (N=58), May-June 2007

### **Intake and Core Assessment**

The Intake and Core Assessment were consistently cited by behavioral health providers as the single most burdensome paperwork process in the state. Notably, the intake and assessment were also cited as an area of major concern during the last and, to our knowledge, only paperwork reduction project (Redman, 2002) commissioned by DBHS.

Paperwork demands at the “front door to services” are widely viewed as a major driver of staff turnover and no-shows for follow-up appointments. The volume of forms and handouts provided at the intake session is viewed as intimidating and overwhelming for clients and family members: “We do not give a welcoming impression,” says one agency director. “Consumers come to see us in their most vulnerable state and the paperwork sets up a dynamic at the front end of service that is

aversive.” Other staff note that consumers are called in for follow-up appointments merely to complete their intake paperwork. Specific areas of concern included:

- Redundancy between different sections of the Core Assessment and addenda that requires clinicians to repeat information in order to demonstrate a “complete” assessment.
- Completion of a full comprehensive assessment for clients with minimal needs (e.g., medication referrals from AHCCCS plans) or briefer stays in the system.
- Consumers and family members required to sign multiple “unfriendly” documents, some of which are too wordy and difficult to understand.
- Duplication of information required between the Strengths, Needs and Cultural Discovery (SNCD), cultural competency items and Crisis Plans for children.
- Problems using the Core Assessment in crisis situations or in response to a referral for CPS 24-hour Urgent Response.
- Multiple Crisis Plans and risk assessments that may be more appropriately addressed at later appointments.
- Lack of clarity on need for updates to Treatment Plans and Annual Review of Progress.
- Need to ensure consistency between the Office of Behavioral Health Licensure (**OBHL**) requirements for assessment and treatment plan and DBHS assessment and service planning process (e.g. when is it appropriate to use the Interim Service Plan? What is the requirement for the Annual Review?).
- Redundancy of the Review of Progress with the Part E Annual Update.

Survey participants also provided copies of multiple handouts and forms given to clients during the intake session. In order to demonstrate “compliance” with requirements to provide the information, consumer and family members are asked to sign or initial the documents.<sup>1</sup> Table 2 specifies the agency of origin for an intake form.

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<sup>1</sup> R9-20-208 and R9-20-203 require signed, dated acknowledgment.  
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Table 2. **Required Intake Forms**

<b>REQUIREMENTS</b>	<b>OBHL</b>	<b>DBHS</b>	<b>RBHA/ Provider</b>
<i>Written list and verbal explanation of client rights</i>	X		
<i>If adult with SMI, written list and verbal explanation of rights contained in R9-21</i>	X		
<i>Explanation of fees/fee schedule/ fee agreement</i>	X	X	
<i>Agency refund policy</i>	X		
<i>Current phone numbers (OBHL, DBHS, DBHS advocates, DES/APS and CPS, RBHA)</i>	X		
<i>Grievance Policy</i>	X		
<i>Written dress code (if residential)</i>	X		
<i>Explanation of secure vs. non-secure (if level 1)</i>	X		
<i>Seclusion and restraint policy (if level 1)</i>	X		
<i>Consent to treat</i>	X		
<i>Informed consent (medication and special procedures)</i>	X		
<i>Release of Information ( family, friends, and other involved agencies)</i>	X	X	
<i>Member handbook</i>		X	
<i>TXIX Screening</i>		X	
<i>TXIX application and documentation (5 forms: consumer drivers license, evidence of other medical benefits, pay stub, etc.)</i>		X	
<i>Co-pay screening</i>		X	
<i>Member rights and responsibilities</i>		X	
<i>Notice of SMI Appeal Procedure (at time of application for SMI determination)</i>		X	
<i>Notice of Right to Appeal</i>		X	
<i>Information on Advance Directives</i>		X	
<i>Core Assessment, Addenda, Medical History, etc.</i>		X	
<i>PCP/Health Plan Release of Information</i>		X	
<i>Release of Information for family, friends, or other involved agencies</i>		X	
<i>SAPT Notice of Right to Religious Objection</i>		X	
<i>Notice of Privacy Practices</i>			X
<i>Other clinical tools</i>			X

DBHS, in collaboration with a statewide committee, has already addressed the size and complexity of the Behavioral Health Core Assessment, with plans to release a revised, briefer Core Assessment in the winter of 2008. **In addition, DBHS is encouraged to develop a Master Signature Sheet or, more preferably, an electronic file with verification, to reduce the number of forms consumers and families must sign at admission. Further, DBHS and OBHL should work together on defining what needs to be signed with an effort at reducing the number of forms while not compromising consumer rights.**

### **AHCCCS Eligibility and Financial Screening**

Closely related to concerns over the lengthy intake and assessment process are issues involving paperwork to establish AHCCCS eligibility. Arizona state law (ARS 36-3408) requires persons who request behavioral health services to comply with “a preliminary financial screening and eligibility process” administered at the initial intake level. Individuals and families who refuse to participate in the screening and eligibility process cannot receive services from the behavioral health system. Most agency staff interviewed recognized the need to screen and assist consumers and families with obtaining health care benefits. However, the process of completing, submitting and tracking the full application for AHCCCS coverage -- including required documentation that consumers must bring to their first appointment -- is viewed as an impediment for persons seeking services who are not currently enrolled in the AHCCCS program. “This is a prime example of paperwork guiding the system,” says one eligibility intake worker.<sup>2</sup>

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<sup>2</sup> Required forms include: AHCCCS Eligibility Financial Screening (1 form - 3 pages), AHCCCS Application and Supporting Forms (4 forms -15 pages). Additional forms for special circumstances: DES Tracking Report, SSA ROI, Disability Report, Employment Verification, etc. Note that the actual number of Paperwork Reduction in the Arizona Behavioral Health System  
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A large number of comments on the eligibility process centered on differences between the roles of AHCCCS and the Health Plans in eligibility/enrollment and the roles of DBHS and the RBHAs/providers. Most agency staff felt that the entire benefits determination/eligibility process has been pushed down to the lowest level in behavioral health where staff are the most overworked and clients are the least prepared to complete the necessary paperwork. While behavioral health agencies are responsible for completing the full AHCCCS application and attachments, the health plans are not. All but two health plan websites reviewed did not include information on TXIX eligibility or health plan enrollment on the site; the two that did provided a link directly to AHCCCS Eligibility Services where potential clients could download their own forms and application. Staff also noted that AHCCCS has developed several innovative electronic aides to assist clients in acquiring and managing their benefits, and would like to see DBHS emulate these efforts.

A related issue frequently cited as a paperwork burden is the DBHS Co-Payment Policy. In general, providers do not believe the policy is manageable and is not worth the time required to collect the small \$1 or \$3 co-payment. “Too much effort to collect so little money from those who have so little cash,” stated one agency CEO. Both OBHL and the Board of Behavioral Health Examiners also require a “fee agreement form.”

The following recommendations related to AHCCCS eligibility are intended to simplify those processes currently viewed as most burdensome to the behavioral health system and clients. We also recommend changing the current co-payment system applied to non-AHCCCS clients.

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forms completed to establish eligibility is the same for behavioral health providers as on the AHCCCS website.

- ***Establish the same standard for RBHA/providers as for Health Plans with regards to eligibility. That is, require behavioral health agencies to complete the preliminary financial screening process only, and establish a fuller eligibility function at the DBHS level.***
- ***Establish user-friendly eligibility tools on the DBHS website, similar to MyAHCCCS.com, the AHCCCS 1-800 number, links to the DES website, on-line applications and instructions.***
- ***Information in Provider Manual 3.1 is very complex and requires highly trained benefit specialists to decipher. DBHS should review eligibility policies, procedures and requirements on the AHCCCS website which are very simple and easy to follow.***
- ***Consider whether TXIX/TXXI screening and referral report is still useful or necessary. Can this manual, process-focused report be replaced with a monthly outcome indicator (e.g., percent of enrollments that are TXIX) based on CIS database enrollment?***
- ***DBHS and the RBHAs should work together in the design and implementation of a meaningful and realistic sliding fee scale process.***

### **CFT Process and Forms**

The final area under the Big Three Most Burdensome issues are procedural requirements and reporting associated with children's services and Child and Family Teams. As noted in Overarching Themes, agencies recognize that not all clinical staff are equivalent in terms of education, experience, training and competency and that coaching/training practices are needed to "bring the field along." However, staff do not feel that the current focus on counting teams, facilitators and staff, detailed guidance documents and supplementary tools and frequent audits of medical records, coaching reports and other forms contribute to a mutually respectful state-RBHA-provider partnership to support children and families. "All of the requirements generate information on paper forms that requires staff to wade through lots of paper," says one clinician. "They are killing the CFT process with forms." Examples cited included

Functional Outcomes Measurement, Youth Services Caseload Roster, Monthly Active CFT Report, Monthly Out-of-Home Placement Reports, and new case management rosters. In some cases, these reports duplicate information that already submitted into CIS. Many agencies questioned whether monitoring tools and forms are related to the treatment process and treatment outcomes, or simply measure team functioning. Others suggest that DBHS has not been clear on the expectations for CFT for families with brief system involvement, those who do not want a team, and children who are referred only for medication by their Primary Care Physician. The following recommendations address the CFT process:

- ***Establish a service code or modifier for Case Management when the service is actually a CFT meeting. This would allow the tracking of CFT meeting time without a separate reporting system.***
- ***Identify what data and reports are meaningful and necessary for CFT processes. Use electronic data whenever possible. If it is already captured in CIS or another report, do not ask for it again.***
- ***Develop a small set of standard reports that focus on outcomes and family progress, rather than process, and require these statewide.***
- ***Clarify CFT expectations for brief or lower needs children and reduce the required paperwork and monitoring processes accordingly.***
- ***Clarify the purpose of the Strengths Needs and Cultural Discovery (SNCD), service plan, and CFT progress note. OBHL requires the same information in the assessment, treatment plan, and medical record updates.***
- ***Some staff currently maintain both the treatment plan and the SNCD in addition to the CFT assessments and must cut and paste between the documents in order to meet OBHL, RBHA and DBHS audit requirements.***

## Other Reports and Processes

### Annual Children's Plan

For the RBHAs, the Annual Children’s Plan was cited as a document that consumes many person-hours to prepare and update, includes data that is duplicated in other reports/plans, and does not focus on progress. “Our plan update is now 120 pages,” said a RBHA staff. Redundantly, “Multiple staff are analyzing and reporting on the same data.” Therefore, it is recommended that ***the Annual Children’s Plan should not duplicate data already reported elsewhere. Instead, it should focus on progress toward meeting major system goals.***

### **Inter-RBHA Transfer**

While not one of the Big Three, Inter-RBHA coordination for service transfers was noted as a cumbersome and confusing process by nearly every agency interviewed. Inter-RBHA coordination, detailed in DBHS Policy CO 1.1, appears to be a constant source of frustration for agency and RBHA staff in terms of the amount of information needed to process a transfer, the tight timelines, and the need to collect signatures and coordinate with other involved agencies. The process is particularly difficult in the children’s system with so many stakeholders, including possible changes in the court of jurisdiction. “The policy is predicated on the member letting us know they are moving, but clients simply don’t follow the policy,” says one case manager. “You really can’t do what the policy says.” Therefore, the following recommendations are offered:

- ***Consider developing a policy change that would allow a single consistent Release of Information for the entire state that informs consumers that their records can follow them without obtaining new signatures (as allowed by law).***
- ***Convene a workgroup of RBHA, provider, and DBHS staff to review CO 1.1 (Inter-RBHA Coordination) with an eye to what accomplishes the goal of a seamless inter-RBHA transfer without micro-managing the process.***

**Consider whether the 7 day/14 day timeframes are realistic. Provide ample opportunities and venues for clients to lodge complaints or provide feedback about the transfer process.**

- **Consider having DBHS conduct disenrollment/re-enrollment functions for transitioning persons. This would ensure continuity of care and allow providers to bill for the time needed to successfully transition – even if the transition is “after-the-fact.”**

## **Notices and Appeals**

Notice of service change and grievance and appeals information were consistently cited as complex, burdensome and confusing processes. Agency staff felt that the triggers/events for providing notices and the differing timeframes by type of notice are far too complex. The 22-page TXIX/XXI Notice of Action policy establishes different time standards for a variety of notices. Some examples follow:

- Service Authorization – 14 days, unless a health/safety issue which is then 3 days;
- Termination/reduction – 10 days, on the same day or 2 day advance notice, depending on the circumstance;
- Pre-Admission Screening and Resident Review – 3 days.

The required form also differs for Title XIX/XXI members and non-Title XIX/XXI members. Interview participants felt that **one form and one set of timelines would be a significant improvement**. In addition, agency staff state that the process is confusing and upsetting to consumers and family members, in particular, notices that follow a member’s death and notices following completion of treatment when he member has already signed off on the closure of the treatment plan.

Many of the same issues arose related to grievance and appeals forms and processes, including multiple versions of forms depending upon behavioral health

enrollment; multiple conditions/events that trigger providing notice of a member's right to appeal; and multiple timeframes for providing the notice.<sup>3</sup> Currently all documentation and records are required by DBHS in hard copy, with multiple faxes to all of the people that need to be informed. Participants felt an electronic file would be particularly helpful in managing the paperwork surrounding grievance and appeals. Regarding Notices and Appeals, the following recommendations are offered:

- ***Use a single form and timeline for all notices and/or appeals.***
- ***Combine policies and Provider Manual sections on notices and those on grievance and appeals if possible. There are too many sets of instructions for staff to understand and consistently apply.***
- ***Establish a method for electronic submission of appeals information.***
- ***Review other states' implementation of notice and appeal requirements to determine whether simpler, more streamlined methods are possible.***
- ***Use a form maker to design the actual notice templates. Language and formatting of the notices and appeals are excessively legal and not meaningful to consumers. Use color and graphics to make the documents "friendly."***
- ***Host several consumer/family focus groups to gather input on the current notice and appeals process. Make the Notice and Appeal process much more "customer friendly."***

## **Advance Directives**

Advance Directives are a more recent requirement in the behavioral health system.

Interview participants felt that instructions on the use of advance directives have not been clear, and that the process could be much more simple, quick and meaningful. All

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<sup>3</sup> GA 3.5 requires provision of Notice of SMI Grievance Procedure at application for SMI determination; Notice of Legal Rights at admission for evaluation or treatment; Notice of Decision and Right to Appeal at initial SMI eligibility, decision regarding fees, when the assessment, service plan or inpatient plan of care is developed, provided or reviewed; when a decision is made to modify the service plan or reduce/suspend/terminate a service; and when a person is no longer eligible for SMI services.

enrolled persons must now be sent annual information regarding their Advance Directive rights. Regarding Advance Directives, the following recommendations are offered:

- **Create a database to house Advance Directives.**
- **Review the Advance Directive process and make it simple, understandable, and meaningful.**
- **Consider eliminating the requirement to send annual information regarding advance directives to all enrolled persons. Instead, post information and education in provider lobbies.**

### **Incident/Accident/Death and Seclusion/Restraint Reports**

Interview participants recognized the importance of tracking adverse outcomes in the behavioral health system. Major observations on the reporting requirements for incidents and seclusion/restraint reporting include the following. There are too many sets of instructions; there is a lack of coordination of reporting timelines between OBHL, DBHS and different offices within DBHS<sup>4</sup>; and reports are sent to multiple offices at DBHS. Therefore, the following recommendations are offered:

- **It is recommended that the multiple sets of Incident/Accident/Death and Seclusion/Restraint directives be reviewed, consolidated and condensed where possible.**
- **It is recommended that reports be sent via secured electronic file.**

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<sup>4</sup> **Incident Reports:** OBHL: initial report in 1 day, written report in 5 days; PM 7.4: written report in 48 hours for abuse/neglect; report sentinel event in 48 hours to RBHA; DBHS Policy QM 2.5: Notice QM in 1 day, written report in 3 days.

#### **Seclusion/Restraint Reports:**

- **OBHL:** 1 day to OBHL, CMS, etc.; 5 days for written report
- **PM 7.3:** 5 days to RBHA, Monthly Summary from facility on 5<sup>th</sup> day to RBHA
- **QM 2.4:** Each incident to QM within 7 days of RBHAs receipt and Monthly Summary by 10<sup>th</sup> day
- **PM 7.3:** Monthly incidents report to Office of Human Rights (SMI, Child only) on 10<sup>th</sup> day
- **Performance Specs Manual:** Quarterly report and analysis to QM

- ***Develop secure file methods for electronic transmission, including a web portal for direct entry into DBHS databases.***

### **Annual and Quarterly Network Plan and Inventory**

Both RBHA and provider staff voiced concerns about the size, duplication and complexity of required reports on provider network. “There are 23 areas in the annual plan, with multiple staff analyzing and reporting the same data,” said one RBHA network staff. “So much of it is data DBHS already has. Area A needs to get the info to Area B.” The Network Inventory, in particular, was cited as a significant paperwork burden. Concerns centered on lack of consistency from year to year in how inventory elements are measured and last minute changes to the definitions. “You can’t anticipate for next year,” one RBHA network staff said. “You scramble to get the data because the definitions come out late.” The network inventory is a “nightmare,” another RBHA concurs. “Takes much time and paper and cannot be compared from one year to the next.” Other concerns focused on the type of information collected: “DBHS wants to know FTE providers who provide family support, consumers who provide family support, families who provide family support. The same thing for other support services. You are really counting the same people over and over.” To help simplify matters, ***it is recommended that changes to the Network Inventory required by DBHS be synchronized to the fiscal year, not the inventory report date.*** In addition, we ***recommend a review of the Network Inventory in terms of a) who uses the information collected, b) is the information available from other sources and existing databases, and c) can the information be streamlined or made electronic?***

## Corrective Action Plans

One CEO described the complexity of Corrective Action Plans. “There are numerous plans of correction from DBHS. So much of it requires subsequent training and monitoring with a report back to DBHS. These come from numerous areas of DBHS. You submit to one area, which overlaps with plans required from another area.” A review of the CAP process shows they are very paper intensive, may be required even after the problem has been corrected, focus on what is wrong with the system not what is right, and focus too much on the *tool* (e.g., Independent Case Review tool) used to measure improvement rather than the improvement itself. ***It is recommended that DBHS re-evaluate the CAP process with input from RBHAs and providers. Emphasis should be placed on streamlining and clarifying the process. A single DBHS repository for corrective actions should be established because corrective actions required by different areas of DBHS increases the likelihood of overlapping, being in conflict with one another, or being duplicative. A central registry should be developed to eliminate these problems.***

### Quick Fixes - Recommendations for Electronic Forms and Reports

This section presents a number of “quick fixes” that are relatively easy to implement. Participants identified a number of reports that could be incorporated into CIS or other routine datasets, thereby reducing duplication while enhancing the level of automated reporting:

- ***Human Resources Roster Reports – rather than submitting multiple roster reports with redundant data fields, electronic reporting should allow for updated roster information in a real time fashion.***
- ***Quarterly SAPT Waitlist (1 report) – combine required data for pregnant women and injection drug abusers with the referral log currently used to***

**collect information for measurement of DBHS appointment standards and access to care.**

- **COOL Notices to Parole Officers (as needed) – Substitute an encrypted e-mail containing a weekly list of no-shows for treatment appointments.**
- **HIV Quarterly Activity Report – Crosswalk existing HCPC codes for HIV services and utilize the claims system to capture these services.**
- **Flex Fund Reports - Allow a reusable credit card for case managers. The billing statement automatically generates a receipt, date, type of purchase and amount, etc.**
- **Out-of-State Placement (2 reports) – Monitor the trend line (e.g., number of placements) through a CIS-generated outcome indicator, rather than approving initial placements. Take action on outliers.**
- **JK Structural Measures (3 reports) – Identify a core set of meaningful measures that can be generated through CIS (e.g. placements in residential, Residential Treatment Centers and Therapeutic Foster Care settings), the referral roster, the provider file or other existing databases.**
- **Annual and Quarterly Prescriber Sufficiency (2 reports)– Use claims data to geo-map location and distance traveled according to the number (density) of enrolled members.**
- **Special Assistance (5 reports) – Consider eliminating reports. Instead, have providers designate those eligible in CIS, which would trigger an automatic notice to the Office of Human Rights and Advocates.**
- **PCP Coordination – Develop a protocol for use of encrypted e-mail to share medical and behavioral information for adults with SMI and individuals referred by PCPs, with a long-range goal of web-based access to health records.**
- **Demographic Updates – Establish a clear standard for what timeframe is reasonable for updates. Name, address and insurance can be updated regularly. Clinical information is more difficult as it relies on an update to the assessment, member agreement, etc. We recommend that DBHS involve providers and consumers in developing the update standard and data elements.**
- **Strengths, Needs, Cultural Discovery (SNCD) – Make this report electronic.**

- ***Documents Incorporated by Reference - What do RBHAs/providers really need to know? More than 60 documents were included in the Magellan contract alone. Several were outdated or not documents that involve the RBHA or provider (e.g., PATH, Project MATCH, DASIS, DIG, Olmsted). “There are too many ancillary requirements, spreadsheets, matrices, logs, etc. These are difficult for providers to respond to and are labor intensive for provider compliance.”***
- ***Outreach/Engagement/Re-Engagement – Establish a clear definition of what constitutes an “appointment.” Engagement tracking is “all or nothing. There is no clinical judgment involved.”***

### ***Opportunities: Total Electronic Data Reporting and Electronic Medical Record System***

Based on input from providers and RBHAs, the development of electronic data reporting and electronic medical records can probably make the greatest impact on the “paperwork burden.” These areas must be immediately addressed. However, there are many difficulties and differences of opinion as to how to implement electronic systems. There is no incentive for those agencies ahead of the curve with electronic records – instead there seems to be a punitive aspect to moving away from paper forms. For instance, depending upon the worker, OBHL will not review anything on a computer screen; everything must be printed. RBHAs or Providers do not see DBHS as having taken a leadership role, as efforts seem to be disorganized and haphazard. Therefore, the following recommendations are offered:

- ***DBHS should take the lead in development of electronic data submission and electronic medical record development by hiring an expert in the field.***
- ***Statewide development should be underway in one year with systems in place by 2013.***
- ***The cost to implement, maintain and update computer systems is expensive. This must be addressed.***

- ***Data fields should be standardized, not forms or paper.***
- ***Develop a web-based record with security code for individual clients.***
- ***Computer systems must have ability to scan in hospital records, past evaluations, school records, and medical care that can be maintained as part of the consumer’s electronic behavioral health record.***
- ***Computer systems must have electronic signature capability (R9-20-208 does not require an individual signature for each item)***
- ***Develop computer kiosks for provider wait rooms so that consumers can complete “forms,” participate in consumer health education, rate satisfaction with services, respond to outcome measures, etc.***
- ***Include a coordinated Technical Assistance component when implementing and maintaining electronic systems.***

In addition to the above recommendations on computerization, please see Appendix 2, which contains additional information on this topic.

### **Leadership and Sustainability**

This final section of the report discusses the concept of *sustainability*. By sustainability, we mean that efforts should address and combat “paperwork creep,” that is the build up of paperwork that may not be necessary. Recommendations for leadership and sustainability follow:

- ***It is recommended that DBHS leadership develop a culture of “paperwork reduction” at all levels of the behavioral health system. When new processes, initiatives, reports and policies are considered or when existing ones are reevaluated, the “paperwork burden” on the system should be a major consideration along with the question, “Can this be done more efficiently electronically?”***
- ***Agency respondents also suggested that DBHS improve its oversight of administrative and paperwork requirements implemented by RBHAs as part of the annual review process, including methods to assess and eliminate barriers to using electronic data collection and submission.***

- ***DBHS leadership should adopt the major recommendations made in this report, include them in the Department strategic plan and make a public declaration of support to the Behavioral Health community.***
- ***It is recommended that DBHS assign the responsibility to a key staff member of carrying out report recommendations, including the monitoring and sustainability functions as outlined, and lead DBHS and the behavioral health system toward greater emphasis on outcomes and less on process.***
- ***DBHS should hire a staff person or consultant to lead the development of a total electronic data reporting and medical record system plan. This person must be very knowledgeable and current on the latest national trends. Leadership and communication skills are also needed to facilitate DBHS, RBHAs, Provider and Consumer involvement in developing, implementing and maintaining electronic technology.***
- ***DBHS should name a responsible party at DBHS and each RBHA to respond to questions about policies to reduce answer-shopping and multiple interpretations of policy content.***
- ***Each RBHAs should implement a Sustainability Committee comprised of RBHA and provider representatives to review forms, reports, data, etc., prior to implementation.***
- ***DBHS should centralize a process for policy/procedure changes on an established schedule.***

### References:

Leipold, J. (2008). *Increasing productivity: EHR software helps clinicians provide more effective and efficient care.* Behavioral Healthcare, 27, 10, p. 10.

Redman, L. H. (July 26, 2002), Paperwork Reduction Project Phase I: Final Report and Recommendations.

## Appendix I

### Participating Agencies in the Paperwork Reduction Process

## Appendix 2

### Recommendations: Paperwork Reduction and Electronic Medical Records

By

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1. From a macro perspective, Electronic Health Records and interoperability of these software products are a core element of integrated technological innovation that is beginning to gain national momentum. It is clear that business software across industries is the engine for increased productivity and greatly enhanced information sharing. A variety of national and state initiatives (including on e in Arizona) are promoting rather aggressive timeframes to develop electronic records in health care. ADBHS would be advised to understand national trends with regard to electronic health records, the functionality of electronic health records, and the creative activities of software vendors specific to behavioral health.
  - a. For example, Netsmart in conjunction with Insight Venture Partners, has developed a strong “connected care” concept whereby interoperability is a central component. This system design also includes a “consumer portal” whereby consumers may go on-line and review components of their health record including medications, service plan and the like to keep the consumer informed and engaged in their care. This process is inevitable and behavioral health providers must reconfigure their systems to accommodate technological innovation and consumer demand. The consumer portal also is a mechanism whereby paper records do not need to be copied for the client – reducing paper.
  - b. The concept of a consumer portal is just the beginning. This web portal concept has similar application to third parties such as Primary Care Physicians. Currently without a software hosted “portal” organizations with EMRs can specify secure VPN tunnels and allow access of pre-determined/approved consumer information to PCP’s, hospitals, pharmacies, the courts, etc. That organizations are not yet sharing information in this way simply means the rules or specifications for secure sharing have not yet been established.
  - c. Advances in wireless technology have transformed where and how behavioral health services are delivered while allowing real time data access concurrent documentation without the clinician ever having to take a piece of paper (PHI) into the field. Electronic signatures and signature pads allow clinician’s and consumers to demonstrate agreement to treatment plans or other documentation as needed.

- d. The macro view is that technology is not going to sit idly by while Arizona waits to catch up. ADBHS can be proactive and develop a White Paper to national behavioral health care software vendors regarding EMR requirements, web portal specifications and so on to meet state needs.
2. In as much as electronic data capture, storage and retrieval moves organizations away from paper and paper related processes; paper is reduced and /or eliminated. Although this seems straightforward enough, many organizations have difficulty envisioning functioning without paper and paper related processes. For example, physicians are usually initially uncomfortable unless the physical clinical record is in front of them. The sheet volume of records that are passed from clinician to clinician and from the Medical Records department to doctors and back again are staggering—without the use of an EMR. If the goal is to reduce “paperwork”, then electronic methods (if done well) are by definition not paper processes.

It is important for ADBHS to embrace Electronic Medical Records and other computer uses as a means to reduce or eliminate paperwork. It is equally important for ADBHS to recognize how business processes change or are modified when an electronic medical record is adopted.

3. “Paperwork” requirements as dictated by ADBHS or other entities should be initiated with the forethought and perhaps expectation that forms, clinical information capture requirements, etc. will be developed in an electronic format. Therefore ADBHS is encouraged to have an electronic medical record “mind set” in much the same way other data elements are captured and transmitted to the RBHA’s and to the state.
  - a. The Paperwork Reduction Committee’s work is to examine all elements of paper requirements and paperwork expectations across the state. Thoughtful use of technology will enable organizations to automate most any paper process. My recommendation is to acknowledge and encourage this fact and in particular focus on electronic clinical data capture through the use of electronic medical records.
  - b. It is suggested that ADBHS change its focus from data collection “forms” or “instruments” to output reports. For the vast majority of clinical information it is unimportant how a particular provider inputs the data. What may be important is how the data is presented to meet state requirements or the requirements. There are numerous examples of why in an electronic environment the input, if constrained to a form, may well lead to inefficiencies. The ADHS Cover Sheet is one example where from a data input standpoint, multiple agency individuals may collect and input data at certain intervals during the intake process and the output results in a completed Cover Sheet.
  - c. ADBHS has to be interested in data/information collection reduction and think in terms of information collection that is value-added to the clinical process and that

is captured in a manner that facilitates outcome measures. Text driven responses whether on paper or electronically does not lend itself to easy analysis. Electronic formats can much more easily graph progress on treatment goals, display scored from a multitude of standardized instruments and can “flag” high risk consumers. Once again, as interoperability improves, EMRs will generate automatic emails to doctors, crisis staff the BHP or whomever needs to know something regarding the consumer under a certain circumstance as defined by the clinical best practice standards. This is another process that saves time and paper.

- d. ADBHS has to acknowledge it may take more time and cost to make changes to an electronic health record that to a paper form. This is a trade off. ADBHS should recognize as with paper forms there is training that needs to occur on the new forms—but with electronic records in addition to the training is the development and testing to make sure the data collected results in the desired output. In general, significant and regular changes in data collection/paper is not a good business practice and it is less so when database structures are routinely changed. EMRs help the discipline (behavioral health) to think if the change leads to better treatment decisions or improved efficiency before undertaking the new development. The paper system allows for relatively frivolous changes to occur without as thoughtful an analysis of the impact on clinical and business practices therefore creating more exhaustion over filling out new “paperwork”.

In an electronic world, the clinical staff member must fill out what is on the screen and does not need to worry if they have the proper form and most if not all process changes occur electronically instead of manually.

4. State specifications for electronic archival of EMRs currently does not exist. The lack of such specifications is short sighted. Agency’s that use EMRs must have a paper back up of every consumer record. From a technological and efficiency view this makes no sense. If the state wants to reduce paper then the transfer of medical records from a physical chart to an electronic file that is stored on CDs and/or tape back up is preferred. Libraries have done this for years. The state can develop the protocols for backup/storage standards. I am aware that electronic archival of behavioral health medical records is occurring in other parts of the country.
5. I have heard ADBHS staff say that behavioral health software vendors frighten them because the software company controls the clinical data capture. I hope all of the above has dispelled this concern and the assertion is one that is ill informed and does not add up. Software vendors are in many cases a resource to states due to their knowledge of national trends and of clinical electronic processes that work better than others. But having said that, it is my experience that software vendors will strive to accommodate state requirements. In addition, it is not necessary to mandate that providers of behavioral health use one specific software vendor. All that matters is the output. If the state desires a certain output then the provider and software vendor need to work together to ensure that output. At the same time, the

state has to have recognition of the development processes as described above and allow for the appropriate lead time for completion when output requirements changes.

6. There is much discussion of how to incent organization's to implement EMRs. Undoubtedly grants or other sources of funding are helpful but implementation and sustainability can be difficult if the organization does not have a thoughtful and planned approach to technological transformation. When implemented poorly an EMR causes more business disruption than a paper system. The state can assist providers in helping organizations determine readiness for EMR implementation, provide information for long term planning for sustainability, provide clear return on investment expectations and so forth so that organizations are successful in the transition and that a large part of the success is paperwork reduction/elimination.