Research Paper

Site readiness assessment preceding the implementation of a HIV care and treatment electronic medical record system in Kenya

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A B S T R A C T

Introduction: Electronic medical record (EMR) systems can yield many benefit; however, facilities need to meet certain requirements before they are able to successfully implement an EMR. We evaluated the feasibility and utility of conducting EMR readiness assessments (ERAs) to assess readiness of public facilities in Kenya for deployment of an EMR.

Method: I-TECH supported the Ministry of Health to deploy KenyaEMR, an HIV/AIDS care and treatment EMR developed using the OpenMRS platform, at over 300 healthcare facilities in Kenya. The ERA tool was designed to assess site readiness for KenyaEMR deployment. The assessments measured health facility internal environment in terms of available resources, security, technical infrastructure, and leadership buy-in and support from MOH and stakeholders for EMR implementation.

Results: From September 2012 to September 2014, a total of 381 facilities received at least one ERA. Of these, 343 facilities were rated as highly or moderately prepared to adopt an EMR system and proceeded to EMR deployment. 61% of these sites were set up to implement KenyaEMR at point of care, while 39% were set up to implement KenyaEMR for retrospective data entry. Across 38 facilities not implemented with an EMR, common reasons that prevented the implementation were lack of reliable power, security issues such as lack of grills on the windows and un-lockable doors, and existence of another EMR system at the site.

Conclusions: ERAs conducted in a single day site visit were feasible and were instrumental in determining facilities’ EMR implementation decision. Performing ERAs stimulated engagement of facility-level personnel to cultivate a fertile environment for EMR adoption and ownership. The assessments further assisted in resource mobilization, remediation of barriers to deployment, and increased buy-in from Ministry of Health leadership to support EMR implementation work.

1. Introduction

Electronic medical records (EMRs) have the potential to increase the quality and accessibility of patient data [1–3], improve clinical processes and patient safety through clinical decision support [4–9], and create efficiencies in health care delivery [5,9–11]. EMR implementation requires significant up-front investments in software design and development, implementation and training, clinic-level operating costs, and information technology support [12]. Failures—where providers or patients reject a system—can be extremely costly [13,14]. A critical step to maximize the potential for successful implementation is to assure site readiness prior to EMR deployment [15].

Readiness has been defined as “the extent to which individuals are cognitively and emotionally inclined to accept, embrace, and adopt a particular plan to purposefully alter the status quo” [16]. Researchers and practitioners have defined multiple domains of EMR readiness including: sound technical architecture and infrastructure [15,17–19], alignment of the technology platform with needs and professional interests [16,20], support from leaders and champions [15–18], sense of ownership [20], financial support [15,17,18,21], organizational values and culture [15,17], organizational flexibility to accommodate change [16], preparatory workflow redesign and staffing realignment [17], adoption of EMR-specific policies and procedures [17,21], as well as self-efficacy, favourable attitudes, and skills of system users.
Most of the determinants of EMR readiness are also determinants of successful on-going system use [23].

This manuscript evaluates the feasibility and utility of using ERAs to assess site readiness for implementation of KenyaEMR, an EMR system for HIV care and treatment. EMR readiness assessments (ERAs) were developed as the primary tool for evaluation of site readiness for KenyaEMR implementation. We describe outcomes of administering ERAs on a large scale in Kenya, identify lessons learned in transitioning leadership of the ERA process to the Ministry of Health (MOH), and provide recommendations on efficient use of ERAs for large-scale EMR implementation in low-resource settings.

2. Methods

2.1. KenyaEMR

Since 2009, the Kenya MOH has embraced large-scale deployment of EMRs in public sector hospitals and clinics to support improved patient health outcomes. In September 2012, the International Training and Education Centre for Health (I-TECH) received United States President’s Emergency Plan for AIDS Relief (PEPFAR) funding through the US Health Resources and Services Administration and the US Centers for Disease Control and Prevention (CDC) to develop and deploy an EMR for integrated care and treatment of HIV. This led to the development of KenyaEMR, which was developed using the OpenMRS platform (http://openmrs.org/). I-TECH was tasked to implement KenyaEMR at 300 facilities within four geographic regions of Kenya (Nyanza, Western, Central and North Rift).

2.2. KenyaEMR deployment strategy

The process for KenyaEMR deployment included three phases: pre-implementation, implementation, and post-implementation (Fig. 1). The pre-implementation phase included the process of engagement with MOH leadership and relevant stakeholders, site selection and evaluation of site readiness for KenyaEMR implementation. These activities required MOH leadership and engagement with HIV/AIDS service delivery implementing partners. The implementation phase involved “upgrading of sites” ranked as ready or almost ready to proceed with EMR adoption. The activities conducted during this phase included security reinforcements, hardware procurement, setting up of the local area network, installation of KenyaEMR, training of system users on KenyaEMR navigation and use, legacy data migration, and data quality assessments. The post-implementation phase involved support and maintenance of the system. Through all three phases, I-TECH prioritized system sustainability by transitioning KenyaEMR implementation leadership to the MOH to ensure that the MOH has the capacity to sustain EMR deployments in the future. Additionally, I-TECH established partnerships with local organizations including academic institutions to orient graduates with the knowledge and skills needed to use and support the system as they join the job market.

2.3. Site selection

County Health Records Information Officers (CHRIOs) and other MOH personnel, in collaboration with partners supporting HIV/AIDS care and treatment programs within health facilities (hereafter referred to as service delivery implementation partners [SDIPs]), spearheaded the site selection process and identified sites suitable for KenyaEMR implementation. The selection of sites was guided by criteria

![Fig. 1. KenyaEMR implementation phases.](image-url)
recommended by the MOH staff in consultation with the partners as well as CDC. The criteria specified prioritization of sites that were public health facilities, offered HIV care and treatment services (Comprehensive Care Clinics), had large patient volumes (greater than 500 patients actively receiving HIV care in the facility), and lacked an existing nationally recommended HIV/AIDS care and treatment EMR system (Comprehensive Patient Application Database, or CPAD, IQCare (https://fgiqcare.codeplex.com), or OpenMRS) [25]. After all sites that met the above criteria for prioritization were evaluated, the criteria were relaxed and some smaller sites were included. Across all four regions, the MOH selected sites for EMR implementation on an on-going basis and in batches of 15–20 sites per region. The selection of each batch of sites was guided by targets agreed upon by the EMR implementation teams at the onset of the program. Within the two year PEPFAR-supported implementation timeline from October 2012–September 2014, the team aimed to complete 50–60 implementations every quarter, toward the target of 300 total KenyaEMR implementations. Prior to conducting ERAs, the implementation team cross-examined the proposed site list to authenticate the selection criteria standards and ensure that assessments were suitably targeted.

2.4. EMR readiness assessments

The ERAs were conducted using an assessment tool which was accompanied by a standard operating procedure (SOP) (available on request). The tool was derived from a generic ERA tool provided within the MOH Standards and Guidelines for EMR systems in Kenya, 2010 [26]. ERAs assessed eight domains of site readiness for EMR implementation: facility leadership and management buy-in towards EMR implementation, security, power supply based on frequency and duration of outages, presence of other EMRs, patient load, charts format, server location, and site operations/activities. Assessment teams rated facilities on a consensus basis based upon the ERA responses in three categories, as follows:

i) “Highly-prepared” facilities: a) reported to have power at least 75% of the time and had a stand-by power back-up in place; b) demonstrated adequate security (lockable doors and grilled window) in all or majority of the rooms used for the EMR; and c) had site leadership which expressed full support and buy-in for the EMR system.

ii) “Moderately-prepared” facilities: a) reported to have power at least 75% of the time; b) demonstrated to have security at least in the server room; and c) had site leadership which expressed full support and buy-in for the EMR system.

iii) “Not prepared” facilities: a) reported to lack power for at least 75% of the time; b) lacked a secure server room; or c) had site leadership that seemed hesitant or unwilling to adopt EMR system.

“Highly prepared” facilities adopted KenyaEMR at point of care (POC), where multiple EMR terminals were installed in clinic consultation rooms, while “moderately prepared” facilities adopted KenyaEMR for retrospective data entry (RDE), where a single terminal was installed for data entry. The details of each domain are provided in Fig. 2.

The assessment tool was initially piloted at 15 sites between July and November 2012. This was to derive best practices and lessons to apply during the roll-out phase. Following these initial assessments, I-TECH modified the tool based on the field experience and feedback from the MOH and implementing partners. Sections deemed complex were reviewed and simplified, and sections deemed non-essential were removed.

To improve the efficiency of ERA data collection and results sharing between stakeholders, the paper tool was converted to an electronic format using Formhub (http://formhub.org/), which allowed for data collection via Android devices. Although it was hoped that the MOH and implementing partners would primarily use the electronic version of the tool, it became apparent that some individuals could not access the electronic version due to lack of Android mobile devices while others preferred to use the paper form. As a result, teams reverted to primarily using the paper-based tool.

After these initial ERAs, the MOH and SDIPs began leading the assessments starting in January 2013, with I-TECH continuing to provide technical support. This shift in leadership was driven by the need to ensure greater involvement of the MOH and implementing partners in EMR activities, and to forge local ownership of the EMR implementation process to support sustainability. I-TECH’s implementation team continued to provide advanced technical support, including reviewing the assessment tool and processes, supporting logistics planning and composition of the ERA teams, and validating the data collected by ERA teams for any errors of omission or commission. Each ERA team comprised of 3–5 people, who were mentored and oriented by I-TECH on the assessment process ahead of the activity. The MOH mobilized facility staff to participate while the SDIPs worked with facilities to address gaps identified during the ERAs; both staffed the assessment teams.

Initially ERAs were done in a two-stage process, each involving a site visit by the ERA team: i) assessment and dissemination of the findings; and ii) development of preliminary implementation plans. However, it was recognized that these two stages delayed execution of initial preparation activities. Therefore, the two stages were combined in a single visit, giving the facility management team the opportunity to immediately start planning for the necessary upgrades such as security reinforcements in the EMR rooms and securing the server location as recommended by the team of assessors. ERAs typically took 3–4 h to complete, including debriefing of results and development of preliminary plans with facility leadership.

The ERA process enabled the facility, the MOH, SDIPs, EMR implementing partners, and other stakeholders to commence EMR implementation preparations such as the setting up of the local-area network (LAN), and enabled the assessors to flag key issues that needed to be resolved preceding implementation. Assessments that revealed major gaps warranted delaying or disqualifying a facility from EMR implementation until the gaps were resolved. As assessment results were being analyzed, stakeholders identified areas to provide support and their roles in EMR implementation were clarified. I-TECH was responsible for LAN installation and for providing initial required IT equipment such as the servers and the work stations. Any other infrastructural upgrades were tasked to other stakeholders including the facility adopting the EMR system. EMR committees were formed at sites to provide local management of the process, with I-TECH providing support and technical assistance to each committee.

3. Results

3.1. ERA results

From September 2012 to September 2014, a total of 381 ERAs were completed in I-TECH implementation regions. Out of 381 sites that had ERAs completed, 328 facilities were rated as highly or moderately prepared to adopt an EMR system at their initial assessment (Table 1). An additional 15 facilities found not to be prepared for EMR adoption at their initial evaluation were found to be highly or moderately prepared to adopt an EMR at a repeat evaluation. Thus, in total 343 facilities were found to be ready for EMR deployment.

3.2. Pathways to KenyaEMR adoption

All 343 facilities that the ERAs found to be highly or moderately prepared for EMR implementation proceeded to deployment. However, the pace of deployment was slower than anticipated due to
unanticipated challenges and circumstances on the ground, such as delays in equipment delivery, which forced the implementation team to reduce the rate of assessments. The program experienced significant procurement delays in the period from Oct 2013 to March 2014, which caused a slowdown of both ERAs and EMR implementations conducted and increased the time from ERA to EMR deployment. To minimize the time lag from assessment to deployment, ERAs were carried out in tandem with deployments. All facilities moved sequentially through the three phases of implementation, but in batches of 15–20 sites. Through implementation of the ERAs, I-TECH identified four different routes that sites followed on the path to KenyaEMR adoption: Pathway 1) ERA leading to point of care implementation, Pathway 2) ERA leading to retrospective data entry implementation, Pathway 3) Multiple ERAs leading to eventual EMR implementation, and Pathway 4) ERA leading to decision not to implement (Table 2). In the sections below, we describe each of the four pathways, report the number of sites that followed each pathway, and briefly describe a case study from one site that followed each pathway.

3.2.1. Pathway 1: ERA leading to point of care implementation

POC was considered to be the preferred model of EMR implementation for sites. Two hundred and eight facilities (61%) were found to have consistent power supply, physical security, and managerial buy-in and were recommended to adopt KenyaEMR at POC. All 208 sites went on to successfully deploy POC EMRs, with a median time from ERA to deployment of 79 days.

A case study comes from a district hospital in the Western region of Kenya, with approximately 4000 patients enrolled in the HIV care and treatment program. ERA results showed that the primary source of power in the facility was the national electricity grid, typically accessible at least 75% of the day. Moreover, a generator was available and was normally used as a back-up power source in the event of blackouts. The facility further indicated that no power blackouts had occurred during the month preceding the assessment.

Prior to the ERA, the site leadership had already identified a secure room to house the computer and other IT equipment, with security measures including grills on the windows, lockable doors, security

Table 1
Results of initial EMR readiness assessments.

<table>
<thead>
<tr>
<th>Activity Period</th>
<th>Number of ERAs conducted</th>
<th>Initial ERA Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Highly prepared</td>
</tr>
<tr>
<td>Sept 2012 – March 2013</td>
<td>53</td>
<td>10</td>
</tr>
<tr>
<td>April 2013 – Sept 2013</td>
<td>143</td>
<td>54</td>
</tr>
<tr>
<td>Oct 2013 – March 2014</td>
<td>47</td>
<td>12</td>
</tr>
<tr>
<td>April 2014 – Sept 2014</td>
<td>138</td>
<td>137</td>
</tr>
<tr>
<td>Total</td>
<td>381</td>
<td>213</td>
</tr>
</tbody>
</table>

*15 of these facilities received a second ERA between April and Sept 2014 and were found to be highly or moderately prepared, leading to EMR deployment.
These 15 sites were found not to be prepared for EMR deployment at their initial ERA, but found to be prepared for deployment at a subsequent ERA. Median time from
swiftly addressed the identi-
leadership team was very supportive of the EMR initiative and therefore
physical security of the rooms were recommended during the ERA. The
guards, and security lights. However, several enhancements to the
physical security of the rooms were recommended during the ERA. The

Table 2

<table>
<thead>
<tr>
<th>Activity Period</th>
<th>Pathway 1 N (Median)</th>
<th>Pathway 2 N (Median)</th>
<th>Pathway 3 N (Median)</th>
<th>Pathway 4 N (Median)</th>
<th>Total EMR deployments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept 2012 – March 2013</td>
<td>11 (68 days)</td>
<td>2 (39 days)</td>
<td>0</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>April 2013 – Sept 2013</td>
<td>74 (93 days)</td>
<td>16 (83 days)</td>
<td>0</td>
<td>0</td>
<td>90</td>
</tr>
<tr>
<td>Oct 2013 – March 2014</td>
<td>28 (118 days)</td>
<td>27 (168 days)</td>
<td>0</td>
<td>0</td>
<td>55</td>
</tr>
<tr>
<td>April 2014 – Sept 2014</td>
<td>95 (52 days)</td>
<td>75 (55 days)</td>
<td>15 (428 days)*</td>
<td>0</td>
<td>185</td>
</tr>
<tr>
<td>Total</td>
<td>208 (79 days)</td>
<td>120 (87 days)</td>
<td>15 (428 days)</td>
<td>38</td>
<td>343</td>
</tr>
</tbody>
</table>

*These 15 sites were found not to be prepared for EMR deployment at their initial ERA, but found to be prepared for deployment at a subsequent ERA. Median time from first ERA to
deployment is shown.

3.2.2. Pathway 2: ERA leading to retrospective data entry implementation

One hundred and thirty-five facilities received recommendations to proceed with RDE implementation of KenyaEMR. One hundred and
physical security concerns were
flagged by the assessment team indicating that

3.2.3. Pathway 3: multiple ERAs leading to eventual EMR implementation

In approximately 15 sites, an initial ERA revealed the need for

3.2.4. Pathway 4: ERA leading to decision not to implement

There were 38 ERAs which led to a decision not to proceed with EMR implementation. The most common factors preventing EMR im-
physical security for IT equipment.

Having taken these steps, the facility communicated those changes to the CHRIO and requested a re-assessment to ascertain site readiness. This facility was assessed for the second time five months after the initial ERA. Security was found to be adequate and the facility was

4. Discussion

We found that EMR readiness assessments preceding large scale
deployment of an EMR system at HIV care and treatment facilities in

Moreover, ERAs were instrumental in determining facilities’ EMR adoption pathways. The ideal EMR implementation model was POC, which allows clinical staff to benefit from the decision support system features that are not applicable to RDE implementation. Previous studies have found that clinical decision support features within EMRs offer the potential to improve clinical processes and patient safety [4]. ERAs led to recommendations for POC implementation at 61% of fa-
cilities which proceeded with KenyaEMR deployment. Sites which were

Table 2 The number of EMR deployments and median time (days) from ERA to deployment.
Through ERAs, several strategies were identified that worked well for the implementation team:

i) Setting of targets for both ERAs and EMR implementation on a quarterly basis and in batches of 15–20 sites per region enabled teams to focus on a manageable number of sites during a given period. Short-term targets were guided by overall implementation targets and enabled the team to routinely monitor progress and milestones reached against overall targets.

ii) Converting from the two-staged ERA process to a combined assessment and dissemination and preliminary planning process conducted on a single day. By providing immediate ERA results to facilities, the facility management was able to immediately commence implementation plans and maintain momentum towards KenyaEMR deployment.

iii) Transitioning ERA implementation to the MOH and SDIPs based on lessons learned from the initial 15 pilot assessments. The shift in responsibility relieved the I-TECH technical team from this activity and enabled them to spend more time focusing on highly technical activities while scaling up EMR across 300 sites, and ensured increased involvement of MOH and partners in EMR activities. The presence of a SOP for ERAs and the decision to revert to the use of a paper-based tool for ERAs were critical in ensuring that the MOH could confidently lead the ERA process.

In the end, more than 300 ERAs were led by the MOH and SDIPs. Using a participatory process of engaging with multidisciplinary groups of health care professionals in EMR selection was recognized as a best practice which increases buy-in and readiness for EMR adoption [24]. Our ERA process, with its emphasis on collaboration and synergy of effort between MOH, SDIPs, and I-TECH, fostered buy-in for EMR implementation. We believe this process fostered local ownership from the onset of the implementation and deployment process, a critical condition for successful and sustained EMR adoption and use.

5. Conclusion

The ERAs assisted in resource mobilization, remediation of EMR implementation gaps, formulation of upgrade plans and buy-in from MOH leadership to support EMR implementation work. The process of carrying out readiness assessments stimulated engagement of facility-level personnel to assure a fertile environment for EMR adoption and fostered transition of ownership and leadership of EMR implementation steps to local health authorities. Such local engagement and leadership bodes well for successful and sustained EMR adoption and use.

MOH-led EMR readiness assessments proved to be feasible and useful in determining facilities’ EMR adoption pathways. We recommend that the sites be followed up and evaluated to determine how successful they are in EMR implementation, adoption and use.

Summary points

What was already known on this topic

- EMR readiness assessments can assist in resource mobilization if key stakeholders are involved in the implementation process.
- Pre-screening of sites prior to EMR readiness assessments increases the chances of EMR adoption after the assessment, saving time and other resources.
- Multiple EMR readiness assessments in one site could signify facility’s deep commitment to address the gaps hindering the site to adopt an EMR system.

What this study added to our knowledge

- EMR readiness assessments collect information useful in determining facilities’ most viable path to EMR implementation.

Author contributions

VM and NP designed the manuscript content. VM, SK, GO, SW, WA and NP implemented the program, and VM and AB led manuscript development. All authors give their final approval of the submitted manuscript.

Conflicts of interest

None.

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