
The EMR Switching Playbook

**What Switching Your EMR Actually
Takes: A Field Guide for Behavioral
Health Leaders**

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*Choosing the right EMR is half the decision. The other half
is the move itself.*

kipu.



The Part Nobody Demos

Somewhere between the signed contract and the first stable quarter on a new EMR sits the stretch no vendor demos: the migration weekend, the go-live morning, the week-three slump when the trainers have gone home and the workarounds start to harden into habit. Behavioral health leaders rarely regret wanting a better system. When regret shows up, it almost always traces back to how the move was run.

The good news is that the move is knowable. A substantial body of research now exists on what happens when organizations change EMRs, and it points to the same handful of decisions, made early, that separate a hard few months from a bad two years. Our recent white paper, *The EMR Trust Test*, can help you choose the system best suited to your organization; this guide picks up where the choosing ends, with the practical work of positioning yourself, your organization, and your staff for a move that goes the way you planned it. As before, we're a vendor in this category, and we've written this to be useful whichever system you're moving to. While we hope it's us, the plain truth is that a well-run switch is good for everyone, especially your clients, no matter which vendor earns your business.

Reset Your Expectations

The most consistent finding in the peer-reviewed transition literature is also the least welcome: however firmly an EMR switch gets scheduled as an IT project, it behaves like a multi-year organizational change. A 2023 systematic review of forty EHR-to-EHR transition studies¹ found that clinical productivity, time in the record, provider satisfaction, and even some safety measures typically get worse immediately after go-live before they get better. Emergency wait times in one large system took about a year to return to baseline. Patient satisfaction scores commonly took anywhere from a few months to fifteen months to come back.



You may have heard this called the J-curve. Operators know it as the stretch when everything takes longer and everyone is tired. The point is not to scare you off a switch that's warranted. Staying on a system that can't segment Part 2 data or defend a claim carries its own compounding cost. The point is that the trough is predictable, which means it's budgetable. Organizations that plan for a temporary dip in capacity treat the hard weeks as expected weather. Organizations that expect day-one improvement read the same weeks as failure, and that's when trust in the project, and sometimes the project itself, starts to unravel.

Plan for the J-curve in writing: reduced visit volume at go-live, temporary staffing where needed, and an optimization budget that survives past the first quarter. In a multi-site study of four health systems that switched EMRs², every single one cut clinical capacity during go-live. The ones that did it flexibly, rather than snapping back on a preset date, fared better with their clinicians.

Data: Move Less, Verify More

Here's the counterintuitive lesson from the migration case studies: accuracy matters more than completeness. One large health system that migrated records for over 1.2 million patients³ found that even between similar systems, data didn't map cleanly. Medication instructions, free-text entries, problem lists, and coded values all drifted in translation, and clinicians spent months reconciling records after go-live. A medication name that transfers without its dose, route, and status hasn't been migrated so much as disguised, and disguised data is a snake in the grass: a patient safety problem waiting for its moment. The transition-safety literature documents exactly this failure mode, including conversion-related medication dose errors and incomplete allergy transfer⁴.

The defensible approach has four parts:

- Define a clinical minimum dataset that must carry forward: active medications, allergies, active problems and diagnoses, current treatment plans, and whatever else is needed for safe care on day one.
- Assume nothing about field mapping until clinicians have tested real patient charts, not record counts, against the source system.
- Set acceptance thresholds and a remediation process before conversion, not after.
- Keep fast, read-only access to the legacy record. The research finds clinicians still relying on it a year or more after go-live³, and limited legacy access is itself a documented patient-safety hazard⁴.

That last point deserves emphasis. Behavioral health records carry longitudinal, narrative content such as risk histories, prior treatment response, the clinical formulation built across years of care, and the research on EMRs in mental health settings warns specifically against transitions that water that content down⁵. A structured problem list does not substitute for any of it. Migrate what's safe to migrate, archive the rest where clinicians can actually reach it, and resist the urge to force ten years of history into the new active chart just because leaving it behind feels like losing something.

Before anything else, though, be sure to test privacy, which the mental health literature flags as a make-or-break adoption issue⁵: confirm role-based access for every role you employ, Part 2 consent and segmentation handling, and audit trails your compliance team can pull without a ticket. Every one of these belongs among the gates a go-live date has to pass through, and each is far cheaper to fix while the date still belongs to you.



People: Where Switches Are Actually Won

The technology gets most of the attention during a switch, but the research keeps pointing at change management as the thing that decides how it goes. Four practices show up again and again in the studies of what end users say worked²:

Four pressures deserve particular attention:



1. Explain why you're switching.

Opaque decisions breed resentment, and resentment shows up later as quiet resistance to the new workflow. Tell your staff plainly what the old system couldn't do, what the new one should, and what disruption to expect. Credibility spent here pays back at go-live.



2. Map real workflows with the people who run them.

No single role sees every handoff. Put psychiatrists, therapists, nurses, care coordinators, front desk, and billing in the room when workflows get designed. The intake coordinator knows where the process actually breaks, and it's rarely where the org chart says it does.



3. Decide your customization philosophy up front.

Customize what clinical, legal, or operational requirements demand. Do not rebuild the old system inside the new one out of comfort; heavy customization makes the platform fragile and expensive to maintain. The useful question for every request is whether it reflects an essential requirement or a historical habit.



4. Give your super-users protected time.

A super-user who still carries a full caseload has been handed a second job without the hours to do it. The organizations that stabilize fastest relieve their super-users of routine workload, train them deeply, and keep them funded after the vendor's implementation team goes home. In behavioral health, where a program may run on three clinicians and a shared front desk, that protection takes real schedule surgery. Do it anyway. Then pair it with role-specific, scenario-based training: a therapist learns more from practicing a psychotherapy note and a crisis safety plan in the new system than from an hour in a lecture hall watching someone else click through menus.

Then expect the dip after the dip. Several weeks in, when the at-the-elbow support has left and the workarounds have calcified, users hit what researchers politely call the valley of despair, the low point of the J-curve². A second wave of training, delivered once people have real caseload experience in the system, is when optimization actually lands. Schedule it before go-live so it can't be cut when everyone is busy.

Money: Protect the Revenue Bridge

For the CFO, a switch is a revenue continuity problem with a software project attached. Behavioral health claims are already denied roughly 85% more often than medical claims; a transition adds new documentation patterns, new claim generation, and new opportunities for the thread between them to snap. Baseline your clean claim rate, days to bill, and days in A/R before the move, and define the numbers that will count as success afterward. Healthy behavioral health organizations run first-pass clean claim rates of 92 to 95%, and you want to know how long you're below your own baseline, not just whether things feel bumpy.



Build the revenue bridge like the infrastructure it is. Clearinghouse connections, payer enrollments, and ERA routing all have lead times measured in weeks, and none of them care about your go-live date. Work the old system's A/R down deliberately, decide who chases legacy claims and in which system, and keep enough access to the old billing environment to finish the job. Then watch denials daily in the first weeks, because a configuration error caught in week one is an annoyance and the same error caught in month three is a write-off. This is also the moment the Trust Test matters most: the export terms, data ownership language, and exit costs you negotiated on the way in are exactly what determine how cleanly you can leave.

The Five Gates

Before you commit to a go-live date, the research supports five readiness questions:

01

Can a clinician safely reconstruct a patient's current treatment, medications, risk profile, and history during a live encounter?

02

Can every role complete its highest-risk, highest-volume work in tested workflows?

03

Have clinical teams validated migrated records against source charts?

04

Are super-users protected, escalation paths staffed, and downtime procedures rehearsed?

05

Has leadership actually approved the stabilization resources on paper: reduced capacity, legacy access, ongoing training, and an optimization budget?

Five yeses, and you're ready. Anything less, and the date is a hope.

Any technology switch is challenging, and switching something as foundational as your EMR can be terrifying to even consider. Preparation is what shrinks it back to size. Run this way, the move stops being a leap of faith and becomes a project with predictable phases, named risks, and proven mitigations, one your organization can walk through with its eyes open.

If you're weighing a move and want to see how Kipu handles the parts that matter, migration, Part 2 segmentation, the golden thread from note to claim, we'll show you on your workflows, not ours. Bring this checklist and the Trust Test with you. We wrote them to be used on us too.

[SCHEDULE A CONVERSATION WITH KIPU ►](#)

The Sources

¹Systematic review of 40 peer-reviewed EHR-to-EHR transition studies (2023):

<https://pmc.ncbi.nlm.nih.gov/articles/PMC10593710/>

²Multi-site qualitative study of EHR transitions across four US health systems (42 providers, clinical leaders, and informaticists):

<https://pmc.ncbi.nlm.nih.gov/articles/PMC10593676/>

³Large-scale EHR migration case study (7,000+ users, 1.2M patient records):

<https://pmc.ncbi.nlm.nih.gov/articles/PMC3613040/>

⁴Review of patient-safety hazards during EHR-to-EHR transitions:

<https://pmc.ncbi.nlm.nih.gov/articles/PMC7657707/>

⁵Scoping review of electronic medical records in mental health settings (JMIR Mental Health, 2021):

<https://mental.jmir.org/2021/9/e30564/>

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