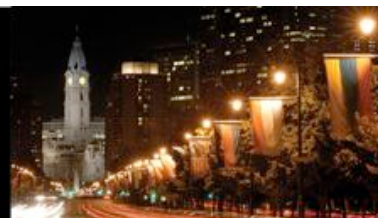


CMS 2010 Regional PACE Conference

November 16 -17, 2010 | Doubletree Hotel | Philadelphia, PA



TRANSCRIPT

QUESTIONS AND ANSWER SESSION

Electronic Health Records for PACE Organizations – Panel Discussion

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It's okay. I'll be right with you. I promised M.J. that I would put that box in front of the microphone for her, and proceeded to walk offstage, because I looked at my phone and realized that it keeps good time so that Dennis and I can stay on track, but I had not turned it on silent, and all I could think of was, "Oh, sweet Jesus, I don't want to be that person." I turned around and thought, "Oh, I'm so sorry." All right. I told you you'd like these girls and I envision us hugging before we go out to have snack here in a minute.

Questions, now, if you have questions, you have to raise your hand. We will get you a microphone. It gets more complicated. I want you to then direct questions to the person -- you got the names up here -- or just throw it out for the good of the group. So do we have any questions? Yes. Okay. We need our microphones. Thank you, Tom. Coming to you. Okay.

Thank you. My question is for M.J. There was a slide in your presentation that I would like you to elaborate on, and that has to do with the clinical record being at the PACE site. One of things that we struggle with at my organization -- and we have an electronic medical record -- is capturing all of the nursing home documentations in the clinical record and housing it at our location when our electronic medical record might not be at our nursing home facilities. That's one question. And also on that same slide there was a notation about incident and accident documentation being in the record. And earlier we heard that we were not supposed to include, you know, incident reports in the clinical record.

Yeah. That piece is exactly from the regulations as far as housing the medical record. As far as years at this juncture, it is -- you know, the maintenance of the record is six years. And as far as that slide, it did say the "documentation." It did not say the "incident report." So for clarification, it's the documentation around the incident meaning, what happened and so forth. So I guess the distinction is the report itself, the incident report, not on the chart. Is that --



Maybe for some of the other PACE organizations that have records, the nursing home documentation, how do you work to make sure that that documentation is captured and kept in one central place in the PACE organization?

I might be able to speak to that. As far as our nursing home documentation, we give a copy of our actual care plan to the nursing home to put in their records so that they have a copy of what we're actually looking for. And then when they have a care planning meeting, we take their hand-written copy of their care plan and scan it into our records. It's not that we have the whole comprehensive nursing home record. That would be ridiculous. But we do have a copy of our care plan in their records, and their care plan is in our records so we can make sure that we're all on the same page and we're focused on all of the same problems and issues with the participant. We also have our staff attend their care planning meetings and vice versa. They come to our care planning meetings, and we invite them – and we go theirs. It's worked for us so far.

I guess I'm not getting the – are you looking at the time frame? Or I guess I'm not understanding your question.

Well, what Christy mentioned, because that's what we are currently doing. We don't have the entire nursing home record housed at our PACE site, and as long as what she's doing is adequate then we're all right.

Well, the spirit of all of the PACE regulations are that the care that you need to provide, which is through the record, would be housed onsite. Are there time periods beyond that? Coordination of care, we find a lot, is not maintained when a person does leave the PACE, you know, onsite, and they go to, say, a skilled nursing facility or a different setting, that care is not – the continuity of that. It's almost like, "Oh, they're off-site now, they're not a PACE participant," and I think that's the spirit of the regulation is that that record be available for the coordination of care and the continuity of care at all levels of, you know, the IDT team.

We're on the same page if we're recognizing the spirit of the intent of the regulation. As long as we're recognizing the spirit of intent.

I think that the PACE regulations, and I think that I speak from, you know, the spirit of them, is that there is flexibility with it. There is not a defining science, as we know, with any – you know, as we saw with Hippocrates; that the holistic point of care or the continuity of care is that it's documented, that it's accessible to the team, and it's in a timely fashion is the spirit of, you know, whether it be electronic or paper information.

Thank you.

Sure.

Question.

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Hi. Thank you very much for an excellent presentation. I just want to make a point of clarification with regard to the documentation of the incident. The documentation or the root cause analysis does not show up in the medical record, but, by all means, any care that is provided around that incident needs to be documented in the regular medical record. So I just want to make sure we're clear because it seems like there might have been some confusion about that.

Thank you. Do we have any more questions? George, I can't see in the back. No? No? All right. Well thank you very much, ladies and gentlemen.