



TRANSCRIPT

Electronic Health Records for PACE Organizations – Panel Discussion

Plan presentations by:

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Centra PACE, we're located in Lynchburg, Virginia. We opened our February of 2009. Our current enrollment is 65 participants, with a max capacity of 125. Centra Health is the only hospital system in our city and five surrounding counties. Centra PACE is one of the many programs that is located underneath that Centra Health Organization. Centra Health operates with an electronic medical record and was recently named as one of the top 100 most wireless hospital systems in the nation. So our challenge was to create a seamless process using our hospital system's established EMR while ensuring that we met CMS regulations upon opening.

Our first step was to meet with the IT Department to discuss creation of the PACE assessment pages. Our hospital system uses the McKesson System. So we wanted to use that system but also create PACE-specific pages, which they currently did not offer. So we were able to create discipline-specific assessment pages that were tailored to the PACE participant. Numerous hours were spent with our IT Department creating these pages. So I hope that you like your IT Department because you develop a very close, close relationship with them.

This is an example of the IDT Plan of Care page that we created. In the beginning, there are just general demographics, the diagnosis, previous team goals that may or may not be applicable depending on if it was a new admission or a reassessment, code status, safety concerns, that sort of thing. Most fields are drop-down boxes, or it can be free text if you need to add more information.

The second half of the IDT Care Plan page represented the team goals, which always included the problem, the goal, the target date, when the goal will be achieved by, the interventions that the staff were going to use to implement to try to achieve the goal, the disciplines responsible for achieving and working on that goal, and then the goal met. Was the goal met or not met? Was it going to be continued in the next six months?

Each discipline also worked with the IT department to create their specific assessment pages. Each discipline had a section for their own problems, goals, and interventions for their discipline-specific plan of care. By requiring each discipline to chart the specific information in the required format that we dictated to them, this ensured that we were capturing all the documentation that was required by CMS in a unified manner. This is an example of our nursing assessment page that we created. It starts with a head-to-toe assessment with drop-down boxes that we found helpful because it saved the nurse time when she was charting her assessment. There's also a section at the bottom for nurses



notes that she can free-text any information that she wasn't able to expand on in the actual drop-down assessment page.

This is the second half of the nursing assessment page, and as you can see, they have their own plan of care with problems, goals, interventions, and target dates. In care planning meetings, if two or more disciplines have the same goal it becomes a team goal that's carried on; an example of this, say a participant with hypertension, the MD and pharmacist will be focusing on medications and that sort of thing to address the hypertension; the dietician may be focusing on, you know, their eating habits and their weight and that sort of thing that would affect the hypertension; and physical therapy may be focusing on their functional ability and their exercise and activity levels, that sort of thing. So if one or more team members brings up that focus in their care plan, then that becomes a team goal and is carried on over in the team page.

This is an example of our transport assessment page. We currently employ five drivers. But ultimately the transportation coordinator is responsible for communicating and coordinating the transportation assessment and the plan of care with his drivers. As you can see, his documentation starts with including basics, like their pick-up time, drop-off time, days in the center, diagnosis that may affect transport. And then the second half goes into the same thing, as you've already seen. He will have his own specific plan of care, any problems, goals, target date, interventions that relate to his transport assessment.

So advantages to using the same EMR as our hospital system, it allows for us a comprehensive medical record that houses all the documentation from the PACE center, from the hospital admissions, and the nursing homes. So anyone within the hospital system, whether they are in the hospital, whether at the PACE center, or a nursing home, can pull up all documentation related to this participant. So, at any time, they can access the PACE information. If they were hospitalized, they can access that information. All of it is accessible to their fingertips.

We're also able to print chronological comprehensive records within a specific time frame that made it easy for us to prepare for CMS audits. CMS gave us a time window that we had to produce our records for, and we were able to print all of those records within that timeframe. And it also allows, like I said, clinical personnel to view records from anywhere in the health system. If one of our participants goes to the ER, then that doctor can pull up the most recent PACE MD assessment, their current medical list, and it's all right there for them, so they're not digging through and wondering.

Some of the challenges that we faced; the development of a process to ensure that all of our paper records were scanned into our record. We do not have a process where we can electronically sign, so anything that the participant had to sign, say, enrollment agreements, consent forms, we had to develop a process to scan that into our record. That required staff to be trained at our center to do that scanning. And right now I'm the scanner, as well as the center manager. We don't have enough staff for the scanning so I am the scanner.



We also needed to develop a system to retain the records per CMS guidelines. We have to keep our original paper records for six years, so that's something we had to take into consideration. Although we were scanning our paper records into the electronic system, we still had to maintain those records. So we had to develop individual files for each participant to house our paper copies for a minimum of six years.

Internal auditing, regular audits are done to ensure that we're being compliant with our CMS regulations and that we're meeting the care and the needs of our participants. We do this in two ways. We have an administrative that do consistent charts audits to ensure completeness and the accuracy of charting, and then internal audits are performed by myself when we're completing the team plan of care. I will go through and look at each discipline's charting to make sure that they are charting their problems in the correct format, their goals, that they're putting timeframes on them, that they're achievable and measureable goals, and that they are addressing whether the goals have been met or not met and whether they will be carrying them over.

CMS audits by having an electronic medical record. This allowed for us to print specific sections for our audit. We were able to print the entire medical record and place it in a notebook with the 18 specific tabs for each participant medical record that M.J. requested. So we printed the entire medical record within that time frame and placed it into a notebook under the 18 specified tabs.

This is an example of one screen shot from our McKesson System. It shows that you can prevent – print results within a specified time frame, vital signs, it gives you a comprehensive view of vital signs, orders, anything that's in the medical record you can pull up and have a chronological time frame of that.

And this is just an example of a page that I have scanned in. On the left side you can see that is the entire PACE record, and so that if I needed to print anything, I could easily go to that medical record and say there's my consent section, print all the consents, and put it in the notebook in preparation for our CMS audit. All of the hospital personnel can also pull that up so that if they are hospitalized they can go right into that chart and see that, "Oh, they have a DNR," "Oh, they have already advanced directives in place," and it's easily accessible to them. I am going to turn this over to Kim and she is going to tell you about our electronic medical record and quality.

Yes. I am standing on a box. My medical is that I'm vertically challenged. My kids have made me promise to stop climbing the shelves in the supermarket.

(INAUDIBLE).

It depends on which day it is and what's on the top shelf. Dr. Davenport [PH], this morning, stressed the importance of data, and I find that the EMR is critical to gathering that data. For quality plan, we use it retrospectively and prospectively. One of the ways we use it prospectively, you probably recognize this from IDT meetings. Well oftentimes we look at it on the individual patient. But what about the processes that deliver these



care, and that's one of the things our team has done is we have developed an aggregate method of looking at some of these processes.

The functional status, we measure the Tinetti score when the participant is discharged from PT and is put on their restorative plan. We look at it after three months. The majority of our participants do great, but there's a few that may not be at that Tinetti score that they were when they were discharged. What percentage of that is there? How often does that happen? All of those are questions that help us plan better processes.

Another one is the semi-annual MMSE. Again, I have to make a confession, Christy cover your ears. When we first started out we weren't really, really good at collecting that MMSE in a consistent basis. One of the things that the medical record helped us to do was we could enter a field and then it was captured regularly. Once we got over the fact that we were capturing it, well, as long as we documenting it, and I was looking to see if we were capturing it, why not add, are we consistently keeping our folks at a high level, and if not, are we addressing if they should have had a drop? Are we addressing that drop.

Recreation therapy goals is one that we look at for social and behavioral functions. Recreation therapy; for example, maybe the therapist has put down something about the participant will participate in the regular exercise for balance to prevent falls. Maybe that's the IDT goal is the prevention of falls. Well, you know, I can see my mom – my mom was once an aerobic queen, she'd be out there and she'd do those chair exercises. My dad is far, far too dignified to do anything like that, huh-uh. But now if we could incorporate a way of getting that same type of exercise maybe through gardening, my dad would be all over that.

Physiological and clinical wellbeing, vaccination rates – anybody recently been charting flu vaccinations and starting to do some aggregate data collection for flu vaccinations? We found that we had a little challenge. Again, an electronic medical record helped us discover that the consistent component in that was the folks that did not receive their vaccination in the center. We had a great process for the folks that received their vaccination in the center, but if they were hospitalized or in skilled care we didn't really have the documentation pullover; so an opportunity for improvement presented itself before CMS found out.

Geriatric depression scores, we did a real job at capturing job, and we have done a really, really good job at addressing anyone who has a geriatric depression score greater than five. But one of the reasons we want to look at that in the aggregate is to see are our programs helping to prevent them getting to that five at their reassessments, but also is it seasonal? You know, we're getting into that holiday season. If we start seeing a lot of people who are scoring a five maybe we ought to look into some programs to prevent that from occurring.

End-of-life planning, as Christy shared, this is comprehensive. So the end of life wishes can be seen in our hospital, in our NED, and our nursing home. By looking at this in the

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aggregate, we can address problems. We have one lady who – well we couldn't get her to make any end-of-life plans. She would not sign a DNR. We could not get her to identify medical POA because she's a widow, no children, no surviving siblings, and her religious beliefs include that she will be taken up to heaven on a cloud of glory. And we found finding a POA a very difficult discussion with her. So by looking at that in the aggregate, and looking at that, that came up every month in our monthly meeting – monthly quality meeting, that this was continuing to be a problem. It enabled our social work team to address this in a creative manner, which we now have her identifying a medical POA, so throughout the system, this person will be helping to make decisions for her in the event that she is unable to make those decisions.

We look at our nutrition and weight loss, again, in an aggregate fashion. Retrospectively, I can't tell you how wonderful the electronic medical record is. I heard these ladies talk about how you can stay at your desk. I can remember a time where I would have to take all of my papers down to the Medical Records Department and I'd have to sift, and sift, and sift, and, "Oh, I'm sorry, we couldn't find that chart right now, you'll have to wait," or "Another discipline is using that chart," and you're playing hide-and-go-seek with the chart. Now everything I need is right there at my desk.

I can query by data or by discipline – I'm sorry, by date or by discipline. This is an example of what I look at when I have queried for the home care. And this is just an example, and maybe I'm using it as a level two RCA or maybe as a part of a death review. But we're looking at everything that happened to that person in the home care, and I can then sift on back through that home care. Also by date, I can look at what was going on with that participant around the date of that event.

It being an integrated EMR, we can look at it wherever – we can look at the events wherever they happen. Now I'm going to share with you a couple of things. I had the opportunity to present – be a part of a team that presented our – using an RCA to improve the admission to the ED. We found that we had – we didn't have a process, and I was able to present this at the San Francisco conference. We didn't have a process and everything was all higgly-piggly and we used the tool of an RCA. You like that term "higgly-piggly", yeah. We used an RCA to help us basically define our process and what did we want to accomplish.

Well now I have to tell you part two of this. Part two was our process was going along well, but we kept having ED admissions, and they were not really – why did they go to the ED? And so we decided we would go and do an in-depth study on what was going on with our ED admissions. This was very, very helpful because I had a lot of the information right here, as you can see it on the screen. Our team just knew, you know, we just knew that it was going to be day of the week; that people were going to go to the ED on weekends rather than Monday through Friday. You ready? We were wrong. Only about a third of our people went to the ED on the weekend. Well the next thing we knew was that it was going to be after hours. You know, that they weren't going to go between 7:30 and 5:30 when the center was open because, certainly, they were going to call. They were going to go between, you know, 5:30 and 3am. Guess what? It was about 50/50. About half of them went while the center was open. There you go.

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Also with this sheet we were able to look at ambulance. How did they get there? Did our transport people take them? Did their families take them? Or -- money, money, money -- did EMS take them? We were able to look at admitting diagnosis. Amazing how many people go to the ED for malaise and fatigue, a cough, pain in the limb. We did look at CHF. That was one of our big ones. So now we have developed some protocols in our clinic or are in the process of developing to identify CHF and better treat our CHF. Here's one. Cover your ears, M.J. 32% of our participants went to the ED related to a fall. Put right back into our fall -- we already had a team that we're working on preventing falls and especially falls with injury, you better believe that reignited that team's desire to reduce our falls.

Bottom line, from the statistician's point of view, there was nothing statistically significant. The only thing I could find that was highly likely, again, not statistically significant, was that folks were more likely to be hospitalized if they went to the ED after hours on weekends. That was the only thing I could find, and, again, it's not statistically valid yet, but we're continuing to keep track. Did we sit on those laurels and say, "Oh, good, here's the study"? That's one of the things that, as a quality professional, I've often seen is, you know, you go in and you've got this great study and it's pages and you found all these facts, and the team looks at it and says, "Great," and that's it. We didn't do that. We didn't stop there.

We are continuing our family education that we talked about in San Francisco. One of the things we are doing is, our chronic ED people, you know -- I'm sure no one else has those folks that think that the ED is still their primary care physician. We have learned that if we go ahead and treat them in the clinic when they say their leg hurts, we'll go ahead and make sure they see a doctor a little face time with the doctor, it works marvels.

We are utilizing our out-patient department. Our organization has an out-patient department where the physician can meet with the participant or a patient in this out-patient department, so we can utilize our transport to go to this out-patient department on weekends and after hours. As I said, we're working with CHF clinics. We have an active fall team. And the latest thing -- folks in quality may have heard the phrase "steal shamelessly"? Well, we have stolen shamelessly from one of our sister organizations in Centra.

Our Home Health department has this wonderful stoplight kind of page. It's a stoplight, you know, green, you're doing fine, everything's good; you know. Yellow, just call the doctor, don't go to the ED yet, call your doctor. Red, go ahead and call the doctor -- I mean, call the EMS because you need to go, but give us a call so we know what's going on so we can call and report to the ED.

And, you know, how do you know, how do you know if your interventions have been successful? You continue to monitor, and we are continuing to monitor.

We've added a couple of fields that we're going to be looking at. We're going to be looking at, did the family, indeed, call? Did we make the decision as an IDT or

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physician's decision to send that participant on to the ED. We are going to find out who the MD on call was to see if it was a little bit more one physician versus another. We're also going to be doing a quick debriefing after every ED visit to determine whether that was avoidable, and if it was, what we can do to help it.

This morning I was really, really tickled, and I know my folks at Centra PACE are going to love this, because Doctor Davenport described quality as a hug, and so now as a quality professional I can hug my PACE organization, and I find that the emergency medical record will let me help me hug this whole group. Thank you.