



TRANSCRIPTS

Electronic Health Records for PACE Organizations – Panel Discussion

Plan presentations by:

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We're going to speak first about implementing the medical record at the Mercy Life Program that was mentioned earlier at another presentation today. This certainly isn't a template for how you would want to do it. I'm sure there is some things we did right that you would want to take a look at. There are certainly some things that, knowing what we know now we wouldn't even do it that way again.

These are our own experiences with this implementation. I just wanted to start talking a little bit about Mercy Life. The Mercy Life Program is a part of the Catholic Health East. Catholic Health East operates eleven PACE Programs along the east coast. Mercy Life is the largest of those programs. It was started in 1989 with one site on Columbus Boulevard in south Philadelphia. In 2005 we opened a second site in south Philadelphia and in 2009 in December of 2009, right after we had opened a site in north Philadelphia we closed one of the south Philadelphia sites and we moved all those participants and staff to the site in north Philadelphia. So that was the month we implemented the medical record. So it was the Christmas month and it was closing a site and moving all the staff and participants and implementing the medical records. So that's one in the don't do it this way column. I mean looking back, you don't always have that much control over it, but looking back over it you really want to look at what are the big main initiatives going on while you're trying to do that.

We currently have 351 participants at the end of 2011 we hope to have close to 500 with 217 FTE's. Our decision to go with an electronic health record of course had something to do with regulatory compliance. Particularly with state reporting requirements and HIPPA and those types of factors. One of the really important aspects in the medical record for us was the ability for our clinicians to immediately access that data off site. So, we're opening a third site hopefully in December, this month, right on Broad Street. So we're going to have three sites. So we have clinicians that are in any one of those sites looking at records and documenting our participants that are at other sites. In addition to that, we have nurses and physicians of course on call in the evenings and on the weekend. We've added a home care staff with field nurses out seven days a week. So all this staff now has the ability to improve their healthcare decision making by having immediate access to that medical record.

We hope to improve efficiency through report writing, quality assurance which Martha will be talking about in a little while and oversight. But most notably it was the efficiency of having that immediate access to the medical record. I can't say that enough because we had lost charts, charts were trying to move back and forth on the van, lab reports here and consultation forms here. It was just very difficult to get your hands on the information you needed. As far as quality, being able to audit easier and trying to keep us in a steady state of readiness was

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important to us. An administrative oversight for immediately being able to look at documentation related to specific instances or looking at documentation on challenging participants that needed some type of administrative intervention.

In determining which system best met our needs, we really found it helpful for looking at how our processes and how our program really works, not how we developed it to work in the beginning. Because as you know when you start the program up you have all these processes in place, and then you hit a critical mass of whether 100, 150 when all of the sudden you're re-evaluating your processes, you're adding staff, you're expanding programming and before you get to a point in a lot of situation where you're doing that, staff have been behind the scenes developing work arounds because what works for 50 people doesn't work for 150 people. So we had to go back and look at the systems we had in place and develop work flows related to that system which we did in close contact with the vendor that we identified. So we didn't always know that there was a work around developed for a process. We found that out by bringing those stakeholders to the table, bringing the end users to the table and saying ok, here it is in enrollments. How exactly do you do an enrollment. Documenting that flow, and that documentation was done by our vendor; that was then sent back to us, we would look at that workflow again in relationship to what we're doing because we wanted that system to work as closely as possible to the way that we did business. This also helped us to identify inefficiencies and duplicative processes. In many cases were the team members were often getting the same bit from all of the participants on the electronic record we just needed that in one place.

From a business standpoint, we considered interfaces between our own internal departments and our internal departments and external vendors. So for instance, we had to make a decision. When the podiatrist or the dentist or the optometrist comes in, do we want them to have access to the record or do we want them to manually document their findings and then scan that into the record. We have a lab interface, we have a pharmacy interface. We have a radiology interface. So you have to make determinations on all of those. We wanted to be able to transfer data to CMS to interface with our TPA and with the lab and the pharmacy. We also did not have prior to the electronic record, we did not have any type of electronic scheduling system. So we wanted a system that could schedule transportation, could schedule home visits, clinic visits, center attendants. So those were one of the things we were looking for.

When determining how you are going to go about implementation, it's important first to come up with the vision. You do that by considering all of those things that I've spoken about already and then to help us do that we put together several committees. We had a steering committee, which was senior management staff, they created the vision, did high level oversight, addressed budgetary issues and approved timelines in order for us to stay on budget. We then had an implementation committee and a clinical committee. Both of those committees worked very closely with the vendor. The implementation committee developed the timelines, planned the implementation and the kick off, worked with the vendor with logistical issues, identified super users and the clinical committee worked on the nuts and bolts pieces of the documentation, the assessments and the workflows.

A few critical elements that bear some repeating, the first one is the work flows. They need to be specifically documented. That's what you hope is going to go into that system so that the system works as closely to what you are used to as possible. Now sometimes the system is not

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going to be exactly the same. I think that some clinicians expect to go into the system and document the way they've always been doing it but just in an electronic format. The system itself will have some built in efficiencies in it. The second one is identification of super users and these folks are the staff members that your staff come to if they have a question about how to use the electronic system. They're not specifically meant to be trainers, but they're the kind of person you tap on the shoulder if you have a problem with the specific part of the documentation or the electronic system. And they usually identify themselves early because these are people who have worked with an electronic health record before or they're particularly interested, they're highly motivated, so they've sort of stepped forward early on in the process to identify themselves as a super user.

It has to be understood by everybody up front that we're getting rid of the paper. People have a tendency to hold onto the paper, it makes them feel better. I've caught myself doing it a few times, you're so used to tracking things that way you're afraid to give it up and let it all go in there because you're afraid that when you go to get what you need you're not going to get back what you have. So it really takes a lot of support from everyone. If people don't feel really comfortable with it they're not going to use the system the way it was intended to be used. For instance, we had a problem with authorizations to where to do the authorization in the system is somewhat cumbersome and confusing to the staff. So when we went back and looked at how authorizations are done, now one year later, we're finding out that there are still paper authorizations going through because people are having trouble. It identifies an area of re-training for you.

Auditing is much easier and also gives you an opportunity to identify where people need training. We did initial training and then we did sort of second level training. Now a year later we're looking at parts of the program that people haven't fully utilized because they haven't spent that much time using that part of the system. So we're looking at additional training even at this point.

The quality of your equipment is very important. Of course you need the laptops, the desktops, the air cards, all those things. But we had a particular problem with scanners. We didn't buy the world's best scanner, then when we found out the amount of scanning that we would need to do and the speed with which we would need to do it, we had to go out and buy new scanners. So looking at that hardware up front is very important. And the transition plan as MJ had spoken a little about that, and Martha is going to talk more about that. You're in a hard copy record, you're going to end up being in a hybrid chart, you're going to be in an electronic chart, so what is your plan for making that transition, knowing that while you're doing it you still need to be able to keep your program running and providing quality care. So you really have to have an answer at all those points across the board at what you're doing as far as documentation is concerned.

So I'm going to turn it over to Martha, she'll talk about quality and preparing for CMS.

There were quite a few financial and organizational impacts that we had that were pretty obvious to us right away. Johanna's already mentioned the immediate access. One of the things that we had done almost at the same time we were closing a center, opening a center and going to an electronic health record is we had transitioned from social workers being on call to nurses being on call. And what we noticed right away was that when a participant called in

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and there was something clinical, we now had the access of pulling that record up immediately and looking at the medications and looking at what might have happened that day at the center. So it really allowed us to get information to our providers to make as accurate of a decision as possible as to what the next steps were. We used to actually carry home at night, three large binders on a rolling cart. Now we just had to go bing and we're up. So that was one of the things that was really an immediate impact.

Communication. We started using the electronic health record doing morning team meetings. So now because you have the ability to route communication during the day, you know all that communication can be sent to the team and then it comes up in the morning. So it's readily available for all that communication that went back and forth and to help improve where we want to update, what needs to happen that day. In particular, we can see what we do have our on-call system is through an answering service, so it does come in in the morning to track all the calls, but it's also helpful if there was a particular incident to really review the documentation. So the on-call people are not giving the whole story, they're just saying go to the record, here's what happened, here's what I did, it's in the record. So it really cuts down on all of that morning listening to the on-call.

It also gave us a chance to really evaluate our data entry and medical records staff. The reality is, is that their jobs have changed dramatically. So there's no longer the duplication of paper in electronic our medical records person is not filing. In our new center our medical records room is very tiny because we just don't have the paper so we don't have to have the space. So it gives you an opportunity to look at what other role they can have and we have found that you know the medical records person is really still key to us, but in a different function in looking at that medical record.

Medical management improved. It's so nice to not have to go to the med cart where the medication record is kept, we can just pull it up, it's available to us 24/7, so that was a very immediate impact to us to just have those meds readily available to us 24/7. Sometimes we'll get calls at night, a van driver can't deliver the meds, somebody's not home. But they are allowed to go where they want to go afterwards. So what they can now do is call the care facilitator on call and say nobody's home for the meds, he or she can pull up the medical record and really look at how critical are those meds, do we really need to go back later in the evening, can we call the primary doctor on call and take a holiday for the night. It just gives us that flexibility.

I think the last one there is the duplication. Just to eliminate a lot of the numerous times one job had to be done, it's now done once, it's saved, it's closed and it's moved on. The finance people though were particularly happy because it does expedite your claims. That's always a very favorable outcome.

So preparing for CMS is, you know, this is the first time that we were really having a survey this past fall. We were, we're still in a hybrid modality, so we weren't quite sure how that was always going to go so it was really important to pick up the phone early and say this is where we are, this is about where we will be when you arrive. So one of the things we did, MJ already had mentioned it, was the mapping. We reduced a document for the surveyors that said that this is what you'll find in the electronic record hopefully that's what you're going to find. This is

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what you're going to find in the hard chart and the hard record. So then you have to go to the hard record, this is why you don't want to stay in a hybrid world for too long, you know, you want to move out of it as quickly as possible. You then have to go to the hard record and you have to tag the charts to say, ok this is what you're going to find in the hard record. In tagging it you also want to be very clear with your surveyors when they say the word print. For some systems printing is push print, for some systems there is a five page directive on how to push print. So you want to be very clear whether your environment is printer friendly or not because it doesn't come out nice and clean like it looks like on the screen. It looks like somebody else's document, like this was what I had on the screen and this was what comes out on paper. So you want to be really clear about the printing question ahead of time.

From an IT perspective, you now have to determine how many computers the surveyors need. Making sure that they have access, its one thing to put the computer down, but do the IT people really understand that you wanted the surveyors to be able to use. All the password protection, all the access, you know, is it wireless, is it wireless that day, is it working. So one thing we did just as a backup is we put in a request to have an IT person on site for the whole week. So the IT Director says for how long, the whole week. We want somebody there for the whole week. What was nice was that very quickly, it is a fairly easy system, and we could move through that system very quickly and we really didn't need the level of support that we needed, but I encourage you for the first time you want that level of comfort.

You know, lets' face it, we want this, it's a stressful enough time, the last thing you want to do is deal with connections not being there or no one is quite sure why you can't make it work that day. We have all had those moments with computers. You just don't want to have them when there is a survey going on.

So the implications for quality, I think what one of the nice things is that we can now quickly identify our population. We can run reports, we can see whose there, we can see what the average age is. One thing that we're still finding a year later is that we're not familiar enough with as many reports as we would like to be familiar with. We don't always know what's available to us. So it's one of those things Johanna mentioned about going back and retraining, one of them will be reports. How do I get the reports out.

It also very quickly identified our high utiliziers for certain services. Who is using home care and to what degree are they using home care. So we can really start to look at our scheduling package a little bit. And auditing, to be able to audit remotely is a wonderful thing for the quality people. We no longer have to sit and wait for the record to be available. We could audit 24/7 if we wanted but we can audit remotely, we don't have to wait for everything to be available to us. And I will say, you had mentioned about knowing then what you know now, we would have audited earlier because it's your first clue that the work arounds are happening, it's the first clue that people went back to the paper, but it's also the first clue that some of that training that you got back a year ago you need to get your vendor to come back and retrain again. So I think we would have hindsight, we would have audited earlier. The audit tool we developed, it's now on revision six, now we've only been doing this for a year, but we keep revising because we don't know exactly what we want to be looking for to what degree we want to be looking for. So it is, it's just a work in progress. It's not because the electronic health record is here you're done, you just have to keep working it.

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But one of the things that it does allow us to do is not look at quality PI projects such as immunizations, it tells us how timely people are doing the assessments, the reassessments because we can run reports to let us know that. It does allow you to be in a constant state of survey readiness. We had nine surveys this year. Between the three centers opening, adult day care, the VA, the homecare licensing, we had nine. So it was nice to have at least with an electronic health record, at least we knew where the information was. Most of the time we knew where it was.

So in summary, you know I would have to probably say the training and the motivation are critical as Johanna said, you have to give, there are people who are going to have a very difficult time giving up that paper, so the training is imperative and I would encourage you almost from the get-go to say ok, we're going to start training in November, we're going to retrain in February. Don't wait you know for six months to eight months to figure it out that you probably want to go back, especially around authorizations. And do not underestimate who has valuable information to share with you on how your company really works. You really need to ask everyone what's the impact around this because everyone has a thought and something to contribute about it. Those committees that you have, you need to make sure that they have someone monitoring that they are on track. Whether you use Visio or Project Manager, you have to help them stay accountable to what needs to be done. The auditing, did we mention the auditing, and the training and refresher courses and the equipment. I would have to say, you know, the scanners were probably the biggest challenge of the entire operation. It's probably another whole topic. Feel free to call us offline and we'll give you some of the tips about that. But in the midst of all the scanning and all the equipment and determining your inventory, we just need to not lose track of the fact of why we're there at the centers. That the participants are there and all of this is hopefully going to improve the quality of care that we're providing for them. Make our decisions more accurate and really make it the best for them as we possibly can.

Thank you.