Implementing an EHR in Long Term Care

A successful EMR implementation in a nursing home requires collaboration among a multi-disciplinary team. While the focus is often on clinical and financial areas, the importance of the health information management function should not be overlooked.
Discussion Points

- EHR Status in New York
- Benefits of EHR
- Drivers of EHR Adoption
- Barriers to Implementation
- Implementation Considerations
- HIM To-do’s
- Impact on HIM Functions
- Physician Engagement
- Copy-and-Paste Function

EHR Status in New York

- 2015 LeadingAge NY survey of 418 LTPAC providers (members of LeadingAge NY which are not-for-profits operating nursing homes, home care agencies, assisted living, ADHC, PACE and MLTC plans)
  - 60% reported full or partial adoption of EHRs
    - concentrated among NH (74%) and home care agencies (68%)
  - Response rate was higher among EHR adopters and the results are likely skewed in favor of providers that have adopted EHRs

At least 40% of New York’s LTPAC providers had not yet partially adopted an EHR
EHRs in New York  (LANY 2015 survey)

<table>
<thead>
<tr>
<th>EHR</th>
<th>Number of Nursing Homes</th>
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<tr>
<td>ADL</td>
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<tr>
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<td>Optimus</td>
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<tr>
<td>PointClickCare</td>
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<tr>
<td>P&amp;P</td>
<td>1</td>
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<tr>
<td>SOS Corporation</td>
<td>3</td>
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<tr>
<td>SigmaCare</td>
<td>21 (significant downstate)</td>
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<td>Answers on Demand</td>
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Benefits of an EHR

- Successful implementation of EHR may lead to:
  - Improved care quality and patient safety
  - Increased employee satisfaction
  - Cost savings to the SNF
  - Increased quality and efficiency in care documentation
  - More complete and uniform care documentation
  - Information immediately available in real time and remotely accessible
  - Improved reporting
  - Integration of MDS completion and reporting

*Health information technology holds tremendous promise for improving health care quality, increasing resident safety and reducing costs.*
Drivers for EHR Adoption

- Despite the lack of financial incentives, SNF providers are implementing because:
  - Changing consumer expectations
  - Quality of care, patient safety, availability of care
  - Administrative efficiency and effectiveness
  - New business models

Driver: Changing Consumer Expectations

- Need to transition to EHR to meet demands of consumer-centric care and transparency to other providers of care
- Requires a culture change within the SNF
  - Few SNFs and EHRs offer residents/family an on-line patient portal or other means to access their health record
  - Many service providers are outside of the SNF and SNFs don’t manage all of the care so resident/family has burden of compiling complete medical history
  - Residents/families have come to expect “hi-tech” in health care
Driver: Impact on Patient Safety, Quality and Availability of Care

- Systems with built-in auditing, monitoring, alerts or other triggers that guide staff to risk and areas needing compliance or re-evaluation promote opportunities to improve patient safety

1. Reduce medication related errors
   - Integrated pharmacy database to enter medications can provide alerts to allergies, drug interactions, side effects, and part D drug billing information.
   - Can complete audit at end of medication pass or shift to alert staff to missed medications/treatments

2. Improved clinical documentation and decision making
   - Charting templates with prompts help improve documentation
   - Database functionality allows user to enter information in one part of chart and it populates in other areas (RAI and MDS)

3. Health information exchange (HIE) – Coordinates care and transitions care between health care providers
   - SNF may be the nursing link for HIE
   - This will be more evident through increased ease and speed of referrals to hospitals and other providers
Health Information Exchange

- US General Accounting Office released February 2017 report that evaluated DHHS efforts to promote HIE exchange by post-acute care providers
  - Factors affecting use of EHRs and HIE
    - Cost
    - Concerns with implementation of health data standards that facilitate HIE
    - Implementation standards for EHRs and HIE
    - Impact of EHRs on workflow
    - Technological challenges such as lack of EHR capabilities
    - The need to train staff to use EHRs
  - Unless HHS improves its comprehensive planning process, GAO warns that HHS risks a failure to meet its goal of increasing the proportion of post-acute providers that send, receive, find and use HIE

HIE in New York SNFs

- 2015 LeadingAge NY Survey found only 31% of respondents reported HIE with a RHIO
  - 30% receive information from or transmit information to a hospital
  - 23% merely view health information in a hospital record
  - 26% receive electronic transfer documents when a patient transitions to their care
  - 14% generate such a document when a patient is transferred from their care
  - 7% receive electronic alerts when a resident presents at the ER, is admitted to the hospital or is treated by another provider
HIE Incentives

- Incentive payments of up to $10,000 per organization are now available to SNF that connect to their RHIO
  - Data Exchange Incentive Program (DEIP) – federal and state funds
  - LTPAC provider must meet following criteria:
    - Have an EHR that is certified by Office of the National Coordinator for Health Information Technology (ONC) for privacy and security and able to transmit data in either the CCD or C-CDA format;
    - Participate in Medicaid
    - Not be connected to a RHIO and contributing data prior to the availability of these funds; AND
    - Not have received funds from another source to create the connection with the RHIO

HIE Incentives

- Organizations receive $2K upon signing a participation agreement with a RHIO and $8K when they attest they have ability to receive a summary of care document in C-CDA format, have established a digital connection to the RHIO and are contributing the required clinical data to the RHIO.
- Limited funding is available – first-come, first-served basis

New York eHealth Collaborative (NYeC)
http://www.nyehealth.org/services/hie-adoption/
Qualified Entities Contacts for DEIP

<table>
<thead>
<tr>
<th>QE</th>
<th>Contact</th>
<th>email</th>
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<tbody>
<tr>
<td>Bronx RHIO</td>
<td>Keela Shatzkin</td>
<td><a href="mailto:keela@shatzkinsystems.com">keela@shatzkinsystems.com</a></td>
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<tr>
<td>HealtheConnections</td>
<td>Danielle Wert</td>
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<td>Rochester RHIO</td>
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<td><a href="mailto:Denise.dinoto@grrhio.org">Denise.dinoto@grrhio.org</a></td>
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**Driver: Administrative Efficiency and Effectiveness**

- Improved data analysis and audits
  - Value Based Purchasing and Bundled Payments
  - Contracting rate enhancements
  - Payer audits
- Coding and links to billing
  - Streamlines MDS, ARD, payment dates
  - Diagnosis codes
- Going green /storage costs
- Record retention and proper safeguarding
Driver: New Business Models

- VBP and bundled payments
  - New business partners looking to use technology to share health information and coordinate care
  - Referral sources may change as hospitals create communication processes built on technology
  - MACRA (Advancing Care Information component) expects interface with other providers
  - Value based purchasing
    - Requires enhanced technology available in EHRs
    - VBP – FY2019 promotes better clinical outcomes and improves care experience
      - 30-day All-Cause Readmission Measure
      - 30-Day Potentially Preventable Readmission Measure

Driver: New Business Models

- Bundled payments
  - Requires enhanced technology available in EHRs
  - CMS Bundled Payments for Care Improvement (BPCI)
    - BPCI Initiative Model 2
      - Retrospective Acute & Post-Acute Care Episode
      - 27 organizations in New York
      - Retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. Medicare makes FFS payments. Total expenditures for an episode is later reconciled against a bundled payment amount (target price).
**Driver: New Business Models**

- **BPCI Initiative Model 3**
  - Retrospective Post-Acute Care Only
  - 10 organizations in New York
    - Parker Jewish Institute for Health Care & Rehab
    - Parker Jewish Institute for Health Care& Rehab: CHHA
    - The Pines at Poughkeepsie Center for Nursing & Rehab
    - VNS of NY Home Care
    - UHS Medical Group
    - UHS Twin Tier Home Health
    - Belair Nursing & Rehab
    - Huntington Hills Center for Health & Rehab
    - Village Center for Care NY
    - Sands Point Center for Health & Rehab
  - Retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. Medicare makes FFS payments. Total expenditures for an episode is later reconciled against a bundled payment amount (target price).
  - [https://innovation.cms.gov/initiatives/BPCI-Model-3/](https://innovation.cms.gov/initiatives/BPCI-Model-3/)

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**Barriers to Implementation**

- Acute care settings and physician practices have quickly adopted EHRs but SNFs have been slower to embrace the technology
  - Funding and Costs
    - No CMS EHR Incentive money
  - Training
  - Complex implementation process
  - Lack of standards adoption
    - CMS and ONC established standards and criteria for structured data that EHRs must meet to qualify for use in CMS EHR incentive programs
  - [https://chpl.healthit.gov/#/search](https://chpl.healthit.gov/#/search)

### LANY 2015 Survey - Implementation Costs

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<th>Cost Range</th>
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<td>$50K - $99K</td>
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<td>50%</td>
<td>$100 - $500K</td>
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<td>15%</td>
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### LANY 2015 Survey - Annual Maintenance Costs

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<tr>
<th>Percentage</th>
<th>Cost Range</th>
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<tbody>
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<td>$50K - $99K</td>
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<td>14%</td>
<td>$100 - $500K</td>
</tr>
<tr>
<td>5%</td>
<td>+$500K</td>
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Implementation Considerations

- Limited funds, staff and on-site IT = heavy reliance on EHR vendor
- Each EHR has own implementation schedule
  - Where does HIM duties fit into the schedule?
  - Does it cover all aspects of HIM related duties?
- Each EHR has a template implementation plan
  - Is it reasonable for each facility?
  - Does it make sense operationally (ex. conversion of data)?
  - Can facility control the timeline?
- EHR Implementation Lead may know EHR implementation but not much else
  - May not have practical experience in SNF operations
  - May know billing but not HIM functions

Common EHR Modules

- Census Management
- Financial
- Customer Relations/Marketing
- Therapies
- Monitoring and Alerts
- Reporting
- MDS
- Emar/Etar
- ePrescribing
- Physician Orders

How many modules will facility use?
Where does HIM fit into each of these modules?
HIM To-Do’s

• Identify all HIM roles/duties
  ▪ Determine how they are changed by EHR
  ▪ Identify which should be moved to/from HIM

• Insist on being a “player” on implementation team
  ▪ Many HIM-related decisions are often made by finance and administration
  ▪ Encourage early participation of billing team members

• Participate in the configuration and set-up of EHR

• Ensure there is adequate HIM-related training
  ▪ Consider general computer literacy of HIM staff
  ▪ HIM super-user(s)

HIM To-Do’s

• Determine EHR impact on HIM staffing needs
  ▪ If reduction in FTE is warranted can they be redeployed?
    ➢ New role related to MLTC case management
    ➢ Role with denial management and documentation improvement programs

• Understand impact of system “down-time” and develop HIM plan
  ▪ What can be done via paper?
  ▪ Develop the climate for change
    ▪ Engage, communicate with and empower staff
    ▪ EHR will improve processes if you are willing to change
Core HIM Functions

Basic HIM functions may remain but processes to complete them will have to change

• Need to embrace process change
• Need to integrate new and progressive work flows
• Need HIM implementation cheerleader
  ▪ Master resident index – new numbering/convert existing, duplicate registrations, amend source documents with accurate number
  ▪ Record assembly – review EHR documentation, complete outstanding data, monitor on admission, concurrent and discharge, scan and index received documents into EHR
    ➢ Without HIE will need to scan documents into EHR
  ▪ Auditing – will still need to track the completion of unsigned reports, un-reviewed labs and missing reports (automated reminders may be generated)

Core HIM Functions

▪ Move from filing and thinning to document imaging – will need quality monitoring processes for completion, retraction, rescanning, retention and destruction. Shift to HIE will reduce imaging duties.
▪ Retention and destruction – policies for paper, hybrid and electronic records. Data management and retention in EHR requires management and oversight.
▪ Release of information and disclosure management – responding to requests will include multimedia formats: HIE, electronic access, printing, CD, flash drives, thumb drives, emails. Management of release is critical for compliance.
  ➢ Documentation required for reimbursement – is it reviewed for completeness?
  ➢ Routine resident transfers – what information printed/sent with resident?
  ➢ Who is allowed to send records?
Core HIM Functions

- **Coding** – encoder technology is not in most SNF EHRs so traditional coding methods will still be required to enter diagnosis codes
  - All diagnosis codes – paint the whole picture
    - Critical for VBP and Bundled Payments
  - Code assignment must be consistent and accurate with documentation, UB04 and MDS
  - Who is allowed to enter new diagnosis codes?
  - Review of diagnosis codes before go-live and entry in EHR

- **Forms management to screen and report design** – new process for designing, reviewing and approving templates, data input screens and reports

Miscellaneous HIM Functions

- On-boarding medical staff / credentialing
  - Ability for EHR to store and track data
- Census management
  - Need in-depth understanding of impact on reimbursement
  - Will finance review financial aspects of census change?
- Mail out all records requests (medical and reimbursement)
  - Mail and assign follow up to other department?
- Submission of MDS
  - Integration with EHR
- Management of physician visit schedule
  - Scheduling made easier with EHR
Physician Engagement

• Basic Problem
  ▪ From a medical record perspective each resident is three patients:
    ➢ the facility’s
    ➢ the attending physician’s
    ➢ the SNF pharmacy’s
  ▪ All three are regulated and must answer to policies and procedures mandated without consideration of respective needs in a “shared” electronic record environment

Physician Engagement

• Consider how each physician is connected
• Engagement level may vary based on connection
  ▪ Community-based doing some SNF work?
    ➢ SNF ~25% of FFS income
  ▪ Part of a SNF Specific Practice serving multiple facilities?
    ➢ SNF >50% of FFS income
  ▪ Employed by your facility?
    ➢ SNF = 100% of Salary
Physician Engagement

• Barriers
  ▪ Many physicians work in other locations and don’t want to learn new EHR
    ➢ Private office
    ➢ Hospital
    ➢ Ambulatory Surgical Centers
    ➢ Other SNF facilities
  ▪ No obvious patient benefit in physicians’ eyes
  ▪ No interface to physicians’ practice

Physician Engagement

▪ Many SNF EHRs do not “embrace” physicians as customers – more like “data entry technicians”
  ➢ SNF EHRs address federal/state compliance mandates of COP, MDS reporting, CMS Survey and documentation required to support billing and audits NOT physician/extender documentation
  ➢ Physician EHRs focus on efficient workflows
  ➢ Physicians are most expensive health care staff and they serve two primary functions in SNF:
    o Generate fee-for-service revenue ($50 - $200+ per hour)
    o Order/approve all other health services
  ➢ Order entry is a wasteful use of a scarce resource
    o Reasonable to expect them to answer call or write order in hall but not to stop daily routines to log into facility EHR to enter complete/compliant order
    o More efficient for trained nurse or pharmacy tech to post verbal orders and have physician perform online review/approval
Physician Engagement

- Ownership of medical records
  - State medical board regulations, CMS reimbursement rules and tort law, require physicians to maintain clinical record
  - Must be produced on demand
  - Problem arises if record is only in facility EHR that is subject to facility control
- Many SNF EHRs don’t have visit note templates
- Most SNF EHRs don’t allow for physician billing (1500 claim format)
- SNF EHRs do not meet regulatory requirements for physicians
  - ePrescribing, PQRS, Meaningful Use converts to MACRA MIPS (January 2017)
  - Reimbursement penalties for not participating in MACRA can be significant
    - 9% reduction of Medicare reimbursement imposed in 2019

Physician Engagement

- Strategies
  - Early communication
    - Timeline
    - Their role/how assist
    - Can they share past EHR experiences
  - Identify the shared purpose
    - Improved quality of care
    - HIE
  - Seek their input on redesigned processes
    - Order entry
    - Nurse rounding and documentation assistance
    - Development of visit templates
    - HIE of notes
  - Appeal to Self-Interest
    - Modification of agreement/compensation
  - Training
    - Timely, convenient, concise
Copy-and-Paste Function

• Risks
  ▪ Copying and pasting inaccurate or outdated information
  ▪ Redundant information in the EHR, which makes it difficult to identify the current information
  ▪ Inability to identify the author or intent of the documentation
  ▪ Inability to identify when the documentation was first created
  ▪ Propagation of false information
  ▪ Internally inconsistent progress notes
  ▪ Unnecessarily lengthy progress notes

Copy-and-Paste Function

• Safety Actions to Consider
  ▪ Develop policies and procedures that address CPF to assure compliance with governmental, regulatory and industry standards
    ➢ Collaborate with providers/clinicians in development
  ▪ Address the use of CPF in facility governance processes
  ▪ Provide training and education on CPF to all users
  ▪ Monitor compliance and enforce policies and procedures
    ➢ Robust quality review process(es)
    ➢ Include a feedback loop to providers
    ➢ Institute corrective action when needed
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