

HRSA Health Information Technology and Quality Webinar

**“Tips For Going Live With Your Health IT
System”**

Date: 10/21/2011

US Department of Health and Human Services
Health Resources and Services Administration

Office of Health Information Technology and Quality

Additional HRSA Health IT and Quality Toolboxes and Resources including past webinars can be found at:

<http://www.hrsa.gov/healthit>

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Additional questions can sent to the following e-mail address:

HealthIT@hrsa.gov

- US Department of Health and Human Services
- Health Resources and Services Administration

Upcoming HRSA Health IT and Quality Announcements

- **HIMSS Jobmine for Safety Net Providers** (Free Job Postings for HRSA Grantees and Safety Net Providers). Email HealthIT@hrsa.gov for more information.
- **Next HRSA Health IT and Quality Webinar**, “Tips For Overcoming the Gray Areas of Meaningful Use Stage 1 for Safety Net Providers” on November 18, 2 PM EST
- **CMS Webinar**, “The CMS EHR Incentive Programs: Small-Practice Providers and Clinical Quality Measures”, October 25, 1 PM EST
- **New ICD-10 Resources**
 - September’s Webinar “Impact of ICD-10 on Safety Net Providers” now online
 - CMS August 3 National Provider Call on "ICD-10 Implementation Strategies for Physicians" Materials now online
- **HRSA Recognizes National Breast Cancer Awareness Month with 2 new grantee spotlights.**
 - Quality Website Spotlight: West End Medical Center, Atlanta, GA
 - Health IT Website: Magee General Hospital, Magee, Mississippi
- **HRSA’s October Health IT and Quality Newsletter now online**

Introduction

Presenters:

- Francis Afram-Gyening: Care Alliance Health Center
- Kirby Craft: Magee General Hospital
- Lynn Hudson: Carolina Center for Medical Excellence

ELECTRONIC MEDICAL RECORDS

IMPLEMENTATION, IMPLICATIONS &
LESSONS LEARNED

By

Francis Afram-Gyening, MBA, MPH, FACHE

Chief Executive Officer

Care Alliance Health Center

EMR GOALS:

Fulfill the mission of Care Alliance in providing high quality health care, patient advocacy, and related services;

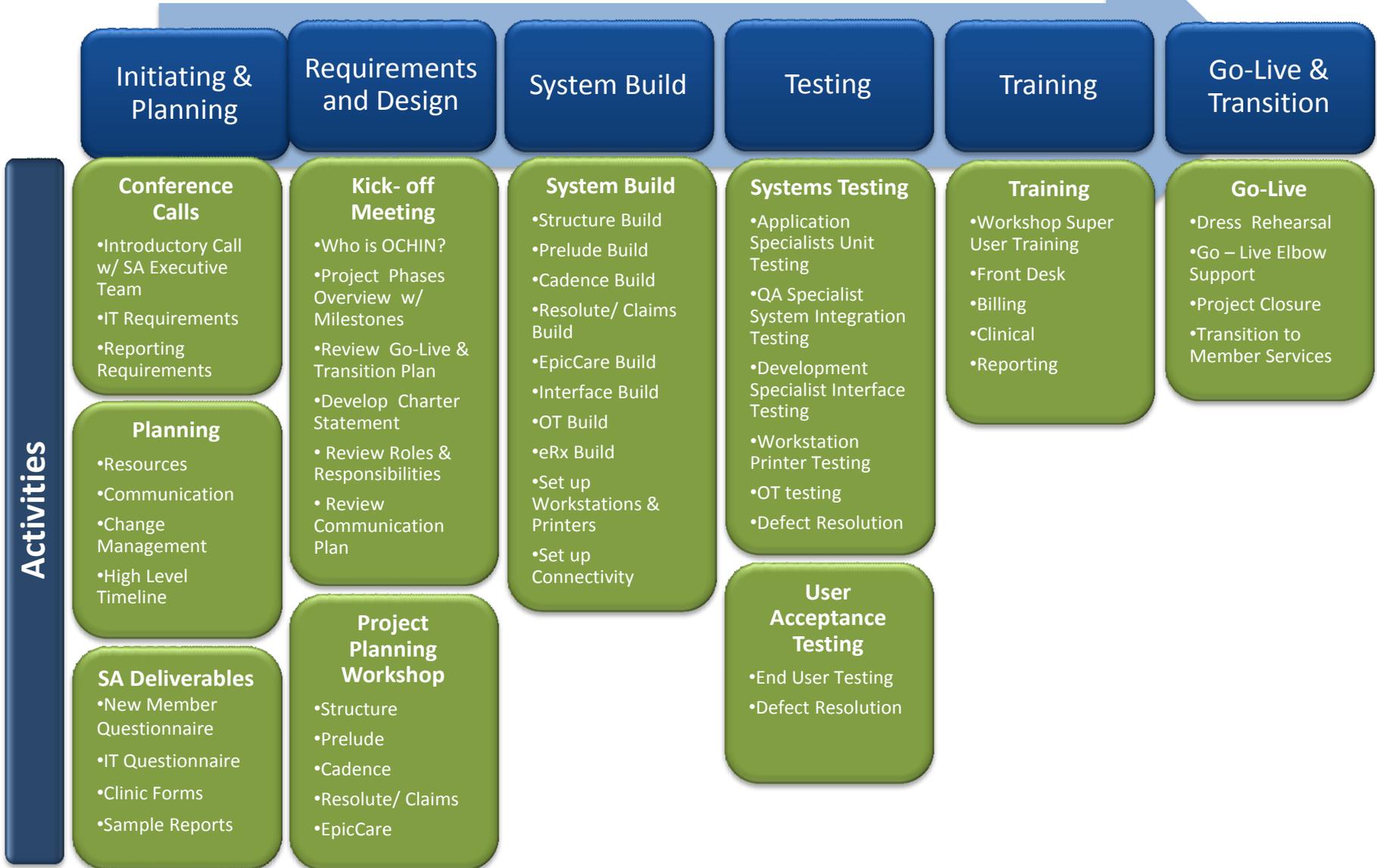
Through the best use of information technology we will enhance practice management, improve clinical outcomes, and develop staff skills;

Keep our competitive edge using paperless technology.

The Players

- Care Alliance Board of Directors
- Care Alliance Staff
- OCHIN
- Federal Government
- Our Patients

PROJECT PHASES



Implementation Milestones



Vendor and Platform
Selected



Kick Off meeting with
OCHIN



Super Users Selected

Implementation Milestones



Learning Management
System Training



CORE TEAM TRAINING



On Site Design/Build

Implementation Milestones



Install Practice
Management System



Complete Hardware
Install at all locations



Verify Connectivity with
OCHIN

Implementation Milestones



More training



More chart abstractions



Dress Rehearsal

Implementation Milestones



GO LIVE



Report Writing



Follow up training

IMPLICATIONS

NEGATIVE

- Financial
- Loss of Productivity
- Work load increase for providers and medical staff
- Stress

POSITIVE

- Better record keeping
- Better health outcomes
- Meaningful use compliance
- Learning experience
- Improved communications
- Easier referral process

CHALLENGES

DESIGN BUILD

- Does the build complement the existing work flow or require a new way of doing business?
- Have all the locations, including outreach clinics, been included in the design?
- Have all the systems been tested in advance, including E-scripting, laboratory connections, and remote access?

CHALLENGES

- OUTREACH LOCATIONS
 - Design needs:
 - Remote access via WIFI, Ethernet, or air cards
 - Testing of remote access
 - Connections to E-Scripts
 - Connections to laboratory
 - Laptops or tablets configured for remote access
 - Work flow processes

CHALLENGES

- **OUTREACH LOCATIONS**

- Place of Service issues

- How many outreach clinics – names, addresses? Have they been entered into the system and is staff aware of how to access? Is staff aware of the names?
 - For example, 2100 now Lutheran Metro Ministries (vendor does not know the street terms for outreach clinics)

CHALLENGES

- OUTREACH LOCATIONS

- Work Flow issues

- Nurse clinics v. provider clinics, ordering supplies and labs, ordering E-scripts
 - Have staff been fully trained on the nuances? Work flow may differ between outreach build and clinic build – different process for different locations

CHALLENGES

- **OUTREACH LOCATIONS**

- **Work Flow Issues**

- How a patient is registered in outreach has to be the same as a patient in the clinic, despite being under a bridge, in a shelter, or at a campsite
 - Computer does not distinguish between places of service in order to enter the record
 - Lots of training required to adapt to new process

CHALLENGES

- **OUTREACH LOCATIONS**

- **Connectivity Issues**

- Remote access requires Internet connection
 - Use of EMR at outreach location only as good as Internet connection
 - When the connection is broken, have to start over or drop to paper
 - **LESSON:** Work with shelter providers to set up remote access

CHALLENGES

- OUTREACH LOCATIONS
 - Work flow issue
 - AFTER VISIT SUMMARY (AVS) – according to meaningful use requirements, must be printed and given to patient
 - EMR requires specialty mapping between computer and printer – not always available in remote locations
 - Need alternative solution to providing AVS

LESSONS LEARNED

- 1) Review Design Build with vendor before Going Live – it's in the details
- 2) Work with pharmacy and laboratory well in advance to advise of changes and ask for input
- 3) Work with outreach locations on Internet connections, changes coming, and potential problems with the system

LESSONS LEARNED

- 4) Test computer literacy skills of all staff before training begins. Work to overcome fear and apprehension of both hardware and software prior to Going Live.
- 5) Test remote access as many times as possible from as many outreach locations as possible.

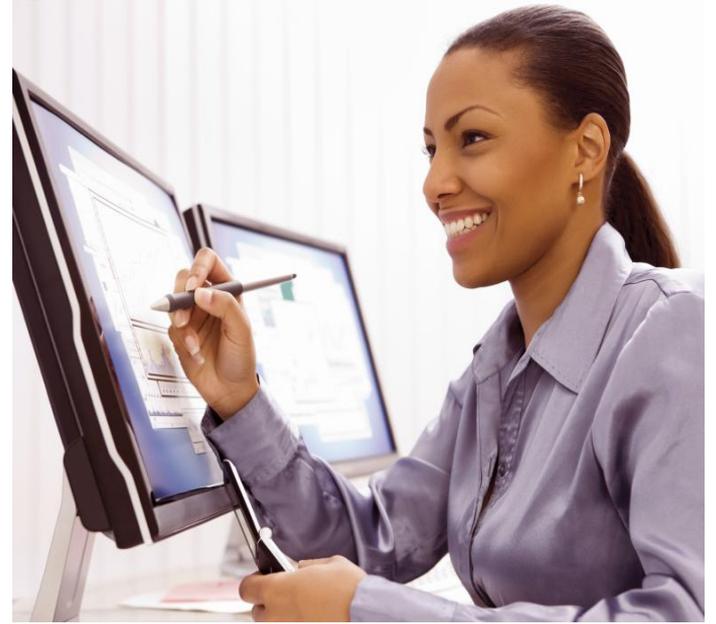
LESSONS LEARNED

- 6) There is no such thing as too much training.
- 7) Plan for the worst, expect the best. While many people resist change, once employees see the benefits of EMR they will embrace the system.
- 8) Develop a security system for laptops and mobile devices in advance.

LESSONS LEARNED

- 9) Designate one person from each work unit to serve on the implementation team. Let the staff learn early on about the challenges that will be faced. Keep the team meeting post-implementation to work on problems. Keep communication flowing!

- 10) Maintain a sense of humor.



Thank You

QUESTION?

Thank You



Welcome to Magee General Hospital



MGH



- About MGH:
- We are located about 1 hour South of Jackson, MS or about 2½ hours North of the Mississippi Gulf Coast.
- Magee General's technology team supports a 64 bed non-profit hospital, 13 clinics, and a variety of outpatient settings. As implied in our size we are not critical access.
- My team supports 22 providers, 16 at 4 different physical facilities and 6 additional physicians utilizing CPOE.
- We had financials and ancillary applications in place with CPSI before upgrading to CPOE.
- We began our CPOE implementation with the installation of POC Aug 2010. Our providers went live with CPOE in Dec. 2010.
- We have completed our 90 day attestation and filed for Medicaid and Medicare incentives.

Hospital vs Clinic



We implemented MU certified EHR solutions in both our hospital and clinic (EP) settings.

There are unique differences in the MU goals of EP vs Hospital so to clarify the remainder of this presentation primarily focuses on the hospital setting of implementing CPOE and achieving MU and focus on how we reduced patient impact during the go-live sessions.

Big Picture



MU vs. CPOE

- Not to minimize the significance of implementing CPOE, but the real challenge is to implement a SOLUTION to successfully and consistently achieve MU. CPOE software, the hardware, the processes modifications, the customizations, training, provider adoption, and security assessments are all required components. CPOE is the means to this end but it is NOT a turn-key solution to achieve MU.
- When you purchase CPOE you have the opportunity to identify how to integrate this into your environment bringing the peripheral components, departments and processes together to not only receive incentive money but to implement a MU SOLUTION that embraces the direction of healthcare.

COST



- Implementing Stage 1 MU is an expensive endeavor. Not only do you have the up front capital but also the recurring increased expenses of maintenance and manpower. Assessing the sustainability up front is prudent.
- Everyone's implementation will be different but a common response is we don't plan to hire additional personnel.
- If you have the surplus manpower to dedicate that may work but to have a successful implementation requires dedicated time to work through the issues and to sustain the expanded infrastructure you are putting in place.

Licensing

- If you initially scoped your project a year ago you may want to revisit the basics before placing the order. You may have expanded the requirements more than you realized. Ex: more different devices, users, licensing, etc
- Add-on licensing can be significant and on the front end it's difficult to completely envision how you will fully implement the project.
- Consider more licenses than you initially expect. Project scope creep is possible. Investigate unlimited site licenses.
- Try to identify your expected CPOE providers in the early stages. Document them to identify license needs.

Preparation



- **Plan, Envision, Collaborate, Lead, be flexible**
- Identify a Project Manager that can see the big picture and lead to achieve the MU goals, implement HITECH security standards, work the attestations, and expand the environment to take advantage of new capabilities.
- Identify a Physician Lead, and get commitment from them in advance to assist with customization and coaching of other providers.
- Identify a Clinical IT person or team, someone that understands your nursing operations and clinical operational flows. This person doesn't have to report to IT.
- Build a MU team and communicate with them often.

Preparation



- Invest time on the frontend to understand the MU goals “in detail” and how you will integrate MU into your business and which of your providers will be using CPOE. What is your longer term vision, example do you plan for your outpatient providers to use the system?
- This seems obvious but with the demands of the implementation, focus on POC and CPOE and meeting the specific numeric metrics, don’t ignore the efforts that need to be ongoing with the ATTESTATION aspects of your MU goals. These can slip up on you and jeopardize meeting your timeline goals.

IT



- If you're not contracting the IT work out assess if your IT team has the technical abilities and capacity to do this work?
- IT teams are often already stretched too thin and this is a significant project. Not only for the physical work to be done but the research, training curves, and .

Jump In



- Do whatever you can now. Don't procrastinate. Not to minimize the importance of planning and researching but there are things you likely can begin doing now to lesson the impact on your team(s) later.
- Even before CPOE is purchased there are things regarding HITECH security that you can and should begin putting in place.
- Once your CPOE solution is ordered be on guard about what I call single threading. When possible, try not to wait for one thing to complete before starting another.
Example
 - Core measure 14 is a security review, you can begin planning this early on, some facilities do this themselves but many are contracting this out.

CPOE (plus)+



- One of the coolest things about expanding technologies is looking for the bigger picture. How is this benefiting other areas. While CPOE has a specific goal the solution you put in place can bring many new benefits to your organization. Be open and ready to lead and expand into these areas.
- A few of the benefits for us:
 - UR & HIM had much faster, easier access to charts and a more complete view.
 - Admissions and ancillary departments tapped into our forms and e-signature capabilities.
 - Scanning demand exploded but also expanded outside EHR to all aspects of running the business. This reduced paper, sped up communications and made information easier to find.

CPOE Hardware



- There's no standard among sites for the hardware that providers want.
- The most common thread I've found among hospitals is a hybrid approach where they provide a mix of hardware to meet provider expectations.
- We implemented a combination of tablets AND desktops.
- We also created designated CPOE rooms on each wing and a designated desktop at each nurse desk. This was a big hit. The providers don't want to struggle in front of patients.
- This has worked well for our environment. Interestingly the desktops are utilized more than the tablets.

Fujitsu T900 Tablet



Basics



- End user training. It's hard to believe that some people in today's workforce still don't know how to use a mouse. You probably have a wide variety of experience in your workforce. Investigate and put efforts into place to train in advance. The fear of failure is often driven by embarrassment or resistance to some of the basics. Conversely mastering these can be quite a sense of accomplishment.
- Carve out some time to train them on the usability of the tablets, slates, or handhelds before go-live week. Since CPOE & POC are software products, much of the vendor training may be focused on the software solutions, problems and processes.
- For POC, barcodes can be a problem. The default behavior may not be consistent with your applications or pharmacy NDC formatting. Test ahead of go live.



Implementation



- To review, we had ancillary and financials in place so at a high level we pick up with POC (Point Of Care) and then CPOE (Computerized Provider Order Entry)
- POC was actually a larger implementation than CPOE. More people are involved and more pieces and process modifications may had to be made.
- I will discuss each and per request of the meeting organizers I will focus on the Patient Impact during go-live

POC Hardware



Point Of Care

Planning, setup, lots of customizations, and lots of training seems to understate the efforts put into getting ready for POC.

It was a steep but rewarding implementation curve.

Some of the issues had to be addressed with process changes.

IT's work included the implementation of POC hardware but many of the items setup during this time were also usable by CPOE.



Point Of Care



Minimizing Patient Impact during go-live

- Our vendor had adequate personnel onsite to assist. Their rollout model included onsite personnel 24x7
- We planned our POC go-live during a traditionally low census period.
- Our D.O.N staffed extra headcount on the go-live days.
- Due to our size and staffing model we choose to train all the nurse supervisors as SuperUsers. This allowed a more highly trained focal on staff 24x7. This is still in place today.
- Our POC focal and IT staff were very responsive and worked long hours to assist, ensure the issues were addressed and everything worked.
- Of course, we went into the venture with our emergency processes handy.
- There were bumps in the road to be fair but those were minimized and buffered by our action plan.

CPOE



Customizations

The technical implementation of CPOE required lots of setup,
working closely with your providers to establish defined order sets
understanding their medication prescribing habits
and being responsive to their requests and any problems.

Training Providers.

- We offered training sessions for our providers.
- We provided one on one assistance and on the job training during go-live
- Our focal is available and on an ongoing basis engages them offering assistance
- We sponsored for them to attend follow-up CPOE conferences

CPOE



Minimizing Patient Impact during go-live

- Similar to the POC implementation our vendor was onsite at times when our providers made rounds. We had focals to work with the providers once the vendor left.
- The patient impact during CPOE go-live was negligible with the most notable impact in longer rounding times.
- Our team choose for all orders to go through the nursing group. There were a number of reasons for this but one of the functional benefits was a check and balance system of sorts.
- Our emergency process is to fall back to paper. Currently about 70% of our providers are CPOE users so some combination of paper

Meaningful Use



Start by getting registered at both federal and state levels

Registering

Federal help: ROATLFM@cms.hhs.gov

Gather relevant information from CMS. A great starting point is https://www.cms.gov/EHRIncentivePrograms/Downloads/Hosp_CA_H_MU-TOC.pdf

Note that 14 of the measures can be obtained from stats reporting from your EHR, however the remainder are “Attestations” that you have met these goals. Some of these attestations are automatic as in “my system is certified”, but others will require action on your part that can require extensive time and money to implement.

Note if your state supports it one of the menu items 8, 9, or 10 is a required menu requirement.



BIO



Kirby has served as CIO at Magee General Hospital since 2007. His career spans a breadth of experience ranging from industrial control systems through all aspects of computer and customer solution support to healthcare. He has worked I.T. since 1979 including 23 years with Hewlett Packard and his productive tenure at Magee General.

Magee General's technology team supports a 64 bed non-profit hospital, 13 clinics, and a variety of outpatient settings.

During his tenure at Magee General the technology program has significantly expanded embracing and integrating a number of new technologies, improving productivity, security and the quality and consistency of healthcare. Meaningful Use has been the culmination bringing together a variety of initiatives to provide an overall solution for their hospital and clinics, using CPSI and Allscripts respectively. MGH has successfully completed the 90 day attestations and filed for both Medicaid and Medicare incentives.

Kirby has presented on Meaningful Use implementations with the Rural Hospital Alliance, the Healthcare Financial Management Association and provided consultation to other entities using similar solutions.

“Tips for Going Live with your Health IT System”

October 21, 2011

Lynn L. Hudson, RHIA

“HITECH EHR Deployment”



- The Carolinas Center for Medical Excellence (CCME)
 - Quality Improvement Organization (QIO) for NC and SC for over 20 years
 - A physician sponsored organization with a mission of improving the quality and cost effectiveness of healthcare
 - Early Adoption of EHR: Doctors' Office Quality – IT (DOQ-IT) 2005-2008
 - EHR Data Reporting: Using Technology to capture and generate quality outcomes 2009-2011



North Carolina REC Involvement

- North Carolina Area Health Education Consortium (NC AHEC)
- 3,500 Eligible Professionals
 - CCME's role
 - Staff Training in the proven methodology for traditional implementation
 - On going training
 - High Level Technical Support
 - Designed the project management web site
 - Designed the EP portal



South Carolina REC Involvement

- The Center for Information Technology Implementation Assistance in SC (CITIASC.org)
 - Health Sciences South Carolina
 - HSSC is the nation's only statewide biomedical research collaborative and is committed to transforming South Carolina's public health and economic wellbeing through research.
- 1,000 Eligible Professionals
 - Consulting Partners
 - SC Primary Health Care Association (SPHCA)
 - SC Office of Rural Health
 - CCME



CCME's SC REC Responsibilities

- Provide direct consulting services to private primary care practices
- Designed a proven methodology for traditional and HITECH implementation/go-live
- Designed the project management web site – milestone driven
- Designed the EP portal
- Provide webinar series for all CITIASC clients



Components of the HITECH EHR Implementation/Go Live

- Registration
 - NLR and SLR
- Certified Technology
 - CPHL
- Meaningful Use Measures
 - 15 Core; 5 Menu Set and 6 CQM
- Quality Improvement (Outcome Reports)
- Attestation
 - AIU
 - Measures



1. Registration

- Credentialing

- National Level Repository (NLR)

- State Level Repository (SLR)

Tools/Tips:

- Medicare/Medicaid Registration User Guide for Eligible Professional (EP)
- National Level Repository (NLR) - Gathering all the required information for each EP



2. Certified Technology

CPHL Certification – End User Focus

- First time the end user was validating a release by a vendor
- Three organizations with varying background expertise
 - Different results with each certification

CCHIT Certification – Industry Focus

- Product Warranty
- One organization



CPHL Vendor Certification Issues

- GAP between the certification version and the version being installed
- MU Reports are not always available
- MU Reports might generate wrong results
- User must purchase additional software to meet MU measures (Patient Portal, HIE)
- Application cannot generate output for MU reports (File/Print)
- Vendor is only certified in a small number of CQM reports



Vendor Delivery Models

- Director Developer
- Valued Added Reseller



Implementation of Certified Version

- Vendor Release Notes of the certified version
 - New Functionality
 - MU Specific Functionality
 - MU Report Functionality
 - Dashboard by Practice/Provider
 - Filtering capability
 - Individual Reports by Mid-Levels
 - Output (File/Print)
- CPHL certification details
 - CPHL #
 - Complete/Modular
 - Additional Software Needed



Certified Technology Impact

- Compare existing work flow to new certified work flows
- Re-engineer processes
- Evaluate software/hardware impact



Planning with Vendor

- Implementation Plan
- Plan schedule go live (waiting list) – schedule date
- Schedule time for training
- Privacy/Security of EHR
- Fully Understand NEW Vendor Certified Work Flow and Reporting Capabilities



3. Meaningful Use Measures

- Provider Level
- Data Driven Measures
- Non Data Driven Measures
- Measures
 - Definition
Metric (Numerators/Denominators)
 - Exclusions



Meaningful Use Tools

- MU Specification Sheets
 - 15 Core
 - 10 Menu Set, Select 5
- Guide to Clinical Quality Measures
 - 3 Core
 - 3 Alternate Core
 - 38 CQM Reports
- CQM Measure Details



Managing Meaningful Use Results

- Tracking measure metrics for each EP
- Implementing new processes until metrics are met



Post Go Live Implementation

- MU GAP Analysis at Practice Level
- MU GAP Analysis at EP Level
- Generate Baseline Reports of data driven measures
- Validate data



4. Quality Improvement

- Managing Non Driven Policies/Procedures
- Administrative Tracking
 - Tracking each data driven measure to meet required CMS/State Medicaid metrics
- Data Validity
 - Ensuring the data accurately represents the EP's work
 - Establishing policies/producers for non data driven measures



5. Attestation Process

- Registration Login/Password
- Reporting Period
- Attestation Worksheets Completed for each EP
- CPHL Certification #
- CMS Certification # (Modular/Complete)



Attestation Tools

Attestation Tools

- Medicare EHR Incentive Program Attestation User Guide for EPs
- Complete Worksheet Tool
- Attestation Calculator
 - Validate data driven measure of compliance
- Each State (Medicaid) Attestation Guide



Post Attestation

Maintain files for each EPs

- Maintain validation documents for the MU data driven reports
- Maintain validation documents for non-data MU measures
- Attestation Submission Page (Attestation ID#) and Worksheets

Audit Process Currently Underway for Medicaid Incentive Programs



Components of HITECH EHR Implementation

- Registration
- Certified Technology
- Meaningful Use Measures
- Quality Improvement (Outcome Reports)
- Attestation



IN CONCLUSION

“Results and Success”



Thank You

Questions and Answers

Lynn L. Hudson, RHIA

Electronic Health Record Consultant

Office of Health Information Technology and Quality

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