Pathway Health Services
Providing pathways to excellence in health care

ePath

21ST CENTURY LEADERSHIP

Insight. Expertise. Knowledge.

USING EHR TO LEAD AND CREATE TRANSFORMATIVE CHANGE

WHAT IF I TOLD YOU IT HAS NEVER BEEN EASIER TO BE A DIRECTOR OF NURSING OR ADMINISTRATOR IN LONG TERM CARE?

Pretty provocative, highly suspect, and downright laughable. That's what I would have said too, 10, 20 years, even 5 years ago. The reality of insufficient reimbursement, higher acuity residents, tough labor markets, and ever increasing levels of government scrutiny, have been pushing long term care leadership to a sink or swim context for years now. We have to be good at so many things at the same time. I started as a CNA, pushed a cart down the hall as a floor nurse, made it to DON where I have failed and triumphed. Now I work along side long term care leaders as a consultant helping providers achieve their goals. I have been wildly stressed, blessed, inspired, and nearly crushed by long term care over the years.

What's different now? Why am I suddenly optimistic about the prospects of being a leader in long term care? You are going to smile and you may say, "yeah right," when I tell you the answer, but hear me out. Our jobs will never be "easy," but easier today than 10, 20, even 5 years ago is within our grasp.

The answer is Optimized Use of the Electronic Health Record or EHR.

Now I did not say just EHR, I said Optimized EHR. The difference is immense and quite real. Many facilities have invested in EHR with all the promises and never saw the return on investment. Why? A host of reasons. Poor planning, poor training from the software vendor, failure to utilize more that 10-15% of the software's real capabilities, failure to incorporate software into staffs daily work patterns/routines, wrong equipment, leadership changes, negative, stalled, or uninvolved leadership, lack of corporate support, and staff turnover, are amongst the most common reasons EHR implementations fail. In the last several years I have been involved in implementations of EHR in hundreds of buildings in 42 states. I have seen it fail miserably and I have seen it completely transform a building. It is possible to truly reap substantial benefit from EHR, but only, only if it's done right. How do it right is the subject of a future article. Today I want to go right to the delicious jelly center.

How EHR can actually make it easier to be a Director of Nursing or Administrator. It's 21st Century Leadership!

MONITORING WORK PROGRESS

It is possible to use EHR to know exactly what things have been done or are being done by staff. Some things we can see in real time. Imagine being able to know in real time where a nurse is at with her medication pass. You turn on your computer, go to a special screen. The screen shows where the nurse on the West hall is at with her med pass. Is she 10% done, 50%, 100%? Which residents has she not given meds to yet and is she late on any of them? A DON can now know these very things by reviewing a window on the dashboard screen of her EHR. She could check this from her desk, or even from her iPAD while at a conference 1000 miles away. Are all the CNAs done with their documentation? Are all the CNAS coding ADLs correctly this week? Did we get all the flu vaccinations done last month? Did we do Braden assessments on everyone last quarter? Are we writing quality Medicare daily skilled notes? Did we measure/assess all known wounds last week? Electronic Dashboard windows and specialized reports in an optimized EHR can give us this information in moments.

What is true for the Director of Nursing is also true for the Administrator. The Administrator could check financial work progress. Did we get all the bills out on time at the end of the month? What is the average age of our receivables? Are we getting back to those folks? Which residents are 30 minutes of therapy away from receiving next highest RUG level? Does therapy know? Are we picking the most advantageous ARD dates, getting highest RUGs possible on all our PPS assessments? These kinds of questions can be answered now in mere seconds by reviewing dashboard windows or running reports in today's EHRs.

In the past many of us would not be able to know these things easily. If we did, it would involve valuable, costly staff time to research these questions. It would be difficult to know, having to review every chart, countless other documents, and constantly interviewing staff. As much as we needed this information, we either could not get it at all, or we didn't have the time it actually took to get it.

Not knowing if work is getting done as expected often ends up causing new problems that hit us during survey, or worse, cause a negative resident outcome. Deficiencies from missing work can be some of the most frustrating deficiencies to get. A system was in place, but work just did not get done. Or worse, the unfinished work results in negative resident outcome and high severity deficiency. These types of problems are largely avoidable now. We now have the ability to know things quickly and easily. We can know right away when work did not get done and intervene to ensure work progress is occurring before survey finds it or before it causes an outcome we all wanted to avoid.

AUTOMATIC EHR STANDARDS. MAKING EHR CONFORM TO YOUR POLICES AND PROCEDURES

Today a DON can set up standards for what needs to be included in a good progress note or particular care plan. The DON tells the computer what a progress note should look like. For example, a nurse pulls up a screen to write a note about infection, and the screen displays different boxes with cues next to each box telling the nurse what items should be included in the infection note. These are called progress note templates.

How many notes do we read where we say, "Why in the world did they write that!?" or "Why didn't they include that?" When progress note templates are set up, we can cue the staff about what should be in that infection note, behavior note, that Medicare skilled note, that note about incidents/falls, etc.

One step further, computer generated notes. We can also define the content of important notes like a nursing admission note. We can have the computer read the admission head to toe nursing assessment and pull out information from that assessment to create what is called a structured progress note. The admission note would be designed by the DON. It would then be written that way by the computer every time with every new admission, but it would pull resident specific individual information in key places throughout the note. The computer generated note may read, "The resident was admitted on," and computer pulls in their admission date. "Resident was admitted from," and it pulls in name of the hospital. "Resident primary diagnosis is," and computer would pull right diagnosis in. A DON can design admission note any way she wants and tell computer when to pull resident specific information in. This process saves time and ensures high quality notes. Its like having the best note writer in the building write every admission note. This could be done for other key notes, like quarterly care conference note, every six month psychotropic medication reduction note and so on. The quality and content we want, every time. The survey results alone would be worth the effort to set this up. Not to mention quality documentation and the resident outcomes that flow from quality processes.

Amazing Triggers. Imagine now that the admission assessment could also trigger the entire temporary/admission care plan. Today's EHRs allow you to build or buy high quality care plan libraries. You can than design assessments to trigger specific care plans from those libraries. As staff answer questions in an assessment, the computer triggers the care plans. The computer triggers only care plans that the DON asked it to.

For example: If we say a resident is at risk for falls on the admission assessment, that answer could automatically trigger our facility's falls care plan. We could even have it trigger specific care plans based on a fall risk score. If a newly admitted resident is scored as high risk for falls, the computer could trigger a specific fall risk prevention protocol/care plan for high risk folks. A facility could use the same process to trigger specific care plans based on other assessed resident needs. Skin risk, communication needs, smoking habits, desire to self-administer medications, specific ADL needs, and on an on. We can an also tell the computer exactly which care plans to trigger from MDS questions. If we code them as having cognitive problems in the MDS, we get the cognitive care plan we set up in our facility care plan library. If we say a resident has diabetes in section I of the MDS, we automatically get our facilities diabetic care plan. The potential is amazing and it is often completely configurable, meaning it can be set up exactly how we want it.

It's amazing what that means in terms of staff time, nurse hours, and quality. By the time the nurse is done with the admission assessment, the admission note and admission care plan have been completed by the computer! The nurse may need to tweak items, but the majority of the work has been done. We turn a 3 step process into a 1 step process. We get higher quality content and documentation, we ensure all steps of admission process get completed, and we get it done in 1/3 of the time it normally takes. The entire process and content is defined by the Director of Nursing, not the software vendor or the computer. That is effective use of EHR. Not just buying EHR, but effective, optimized use of EHR.

There are many other triggers. For example, any assessment can be triggered by opening up a certain type of incident report. Systems can be set up to trigger neuro-checks and the post fall assessment if we open up a fall incident report. The assessments can pop up in the incident report itself, waiting to be completed.

We can trigger tasks from assessments and incident reports for direct care givers. We fill out an incident report or an assessment and a task is triggered to show up on kiosks in the hall way for the CNA to do. For example, a resident is found to have reddened heels or coccyx. This finding, documented in an assessment or incident report, could trigger a task to show up for the CNA to provide pressure relief. Again, we can ensure that all the steps we want to occur do occur. When a problem is identified, we trigger the assessment and the assessment can trigger a note. The assessment can also trigger a care plan and send a message out to staff to initiate new interventions.

EARLY RESIDENT NEED IDENTIFICATION AND EARLY RESPONSE. PREVENTING HOSPITIZATION

Todays EHRS can be set up to use dynamic alerting. It's a way of sending messages right to the staff that need to know. Nursing and other department heads can announce new interventions. Therapy may announce a new transfer technique for a resident. Nursing may announce new fall intervention. Dietary may announce transition to thickened liquids. The information we need to get into everyone's heads right away can get out to staff with effective use of EHR alerts.

Alerts can come up from direct givers to licensed staff as well. CNAS may warn us about a resident that is not feeling well, a resident with new skin areas, or resident's new complaints of pain. Rehospitalization risk conditions can be identified early. CNAS can be electronically asked on their kiosk screens to watch for and report about changes in resident normal behavior, usual patterns. For example CNAs can be asked each shift to identify residents that are not feeling well or less involved in activities. If a CNA documents these early changes in conditions, alerts can go out to licensed staff to further assess and hopefully intervene, possibly preventing unnecessary hospitalization. With these systems in place, we can more easily catch a CHF or infectious episode before it blows up and requires hospitalization.

Advanced Assessment Software. There are also new tools coming on the market that are able to communicate with the larger EHRs in use. These Advanced Assessment software tools are being used by nurses to assess residents with key diagnosis that put them at risk for rehospitalization. These tools pull data such as weights and vitals information from the larger EHR and analyze that data along with diagnosis information to help facilities identify residents at risk for an episode that may cause rehospitalization. The software also gives research based suggestions on the appropriate interventions for nurses to use to prevent rehospitalization. The early change warnings comes in from the direct care givers via their kiosk system and the nurse uses high quality tools, care paths to provide the right assessment and intervention to prevent hospitalization.

24 Hour Watchman. The computer can be set up to recognize changes in condition as well and send out alerts. We can have the computer warn us when resident not had BM in 3 days, not eating or drinking well, has high pulse, change in blood pressure, significant weight loss or weight gain, change in behaviors, or any change we can think of that staff are documenting on. The computer is always on and always watching 24/7. We just tell the computer what to watch for, it reads staff documentation, and alerts the team to further assess and intervene.

ACT NOW ON EHR

For those facilities without EHR, you'll want to get it and get it soon. The benefits of full, effective, optimized use of EHR are transformative. Those without EHR will not be able to keep up with facilities that use it well. Whether is staff recruitment, staff retention, survey results, maximized reimbursement, or resident outcome, facilities using optimized EHR have the advantage over those that do not use EHR, or do not use it well.

As we go into the ACO (Accountable Care Organization) formation phase in 2012 and beyond, hospitals will be looking for long term care providers that can interface with their acute care software and have an EHR that can be configured to build processes to prevent rehospitalization. Hospitals Medicare payment changes October 1st, 2012 with respect to rehospitalization. They simply will be paid less than they have in past if a resident is rehospitalized within 30 days of discharge. These new ACO partnerships are forming across the country. Within these partnerships, referrals will flow largely to those facilities the hospital's pick as partners. Facilities that can prevent unneeded hospitalization will be high on their list of potential partners. All long term care facilities will need to have EHR and be using EHR effectively.

For those with EHR, sometimes a refresher course from an experienced EHR consultant can help you make better use of the system you have. Many folks only end up using 10-15 % of the capabilities of the software they own and are unknowingly sitting on top of amazing tools that could change their work lives dramatically. A good consultant can show staff what is there, how to optimize it's use, and how to help a facility take dramatic steps forward with communication, managing work progress, increasing reimbursement, and achieving better resident outcomes.

Should you need such assistance, Pathway's ePATH team has several consultants that are former leaders in long term care, as well as certified trainers for EHR. We can provide web based or onsite assistance to help providers achieve effective, optimized use of their EHR. Pathway has a special relationship with EHR vendor, PointClickCare. Everything mentioned above in this article, can be achieved in the PointClickCare software. A Pathway ePATH consultant can help get you there.

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