EHRs in Long Term Care

Lisa Wynn, MA, BSN, RN
and
Ashley Wells, BS
Agenda

• Overview of long-term care (LTC) Projects
• Review an OSDH-funded Medication Safety in LTC project
• Review the most commonly-implemented EHRs in LTC facilities
• Review the use of EHRs in LTC
• Review lessons learned and recommendations
Objectives

• State at least 2 EHRs in use in LTC facilities
• State at least 3 ways EHRs are being used in LTC facilities
• State at least 2 issues with EHR use in LTC
OFMQ and Long-Term Care (LTC) QI

- LTC projects began in 2002. Almost 14 years! Over 200 homes!
- Projects funded by CMS and/or OSDH
- Projects focused in improvement in specific Quality Measures, implementing Culture Change and applying Quality Assessment/Process Improvement (QAPI) principles
- Projects included onsite technical assistance, regional and virtual educational conferences, and creation/provision of numerous tools and resources
OFMQ’s Current LTC Projects

• 2 grants through OSDH, funded through the Civil Monetary Penalties (CMP) funds from CMS
  – Improving Healthcare Acquired Conditions in LTC (60 homes)
  – Improving Medication Safety in LTC (8-12 homes)

• Today’s presentation will focus on the Medication Safety project
Med Safety Project Summary

• 3 years:
  – 4 homes in Yr 1
  – 8 homes in Yr 2
  – 12 homes in Yr 3

• Comparing EHR vs non-EHR use in the Medication Administration process

• Partnering with Oklahoma University College of Pharmacy (OUCOP)
Project Roles

OUCOP
• Medication review
• Staff education
• Direct intervention
• Project data collection

OFMQ
• Project management
• Workflow analysis
• Statistical analyses
• Make recommendations & report findings
Project Experience: EHRs Implemented

- Caretracker & AOD (1 home)
- HealthMEDX (1 home)
- PointClick Care (5 homes)
- VorroHealth (1 home)
Project Experience: Workflows
Project Experience: Med Room
Project Experience: Medications
Project Experience: Med Carts
# Project Experience: Use of EHR

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Caretracker &amp; AOD</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>HealthMedX</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>PointClick Care</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>PointClick Care</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>PointClick Care</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>PointClick Care</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>PointClick Care</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>VorroHealth</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
EHR Benefits

- PRN Medications
- Lock chart
- Medications that are overdue
- Medications due now
- Medications due at next shift
EHR Benefits

Reminder to take blood pressure
Project Experience: Barriers

- $$ per module → no implementation → ↓ use for med processes (including alerts), ↓ physician access/use, ↓ HIE connectivity
- Change in ownership → change in EHR vendors → ↓ functionality
- ↓ project homes using EHR or ↓ time implemented → unable to make meaningful EHR use comparisons at this time
Project Experience: Issues

• Minimal – no use of EHR reporting functionality
• LTC as “home” is a good thing, but brings its own challenges
• Where there is duplication of records (most cases) there are issues of where the legal record resides
• EHR focus in LTC is in meeting CMS’ MDS documentation requirements
The Impact of Meaningful Use and MACRA on Long-Term Care

Issue Number:
Volume 24 - Issue 4 - April 2016
Author: Rajeev Kumar MD, CMD, FACP

The Electronic Health Record (EHR) Incentive Programs developed by Centers for professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate “meaningful use” of certified EHR technology.¹

In July 2010, CMS published a final rule that established three phases of the EHR Incentive Program. These three stages were designed to support eligible professionals and hospitals with implementing and using EHRs in a meaningful way to help improve the quality and safety of the nation’s health care system. Stage I of the EHR Incentive program began in 2011, with Stages II and III to be established by future CMS rules.² Simply put, “meaningful use” means that providers need to show that they are using certified EHR technology to improve quality, safety, and efficiency in measurable ways.
... while we [physicians] were given incentives to purchase EHRs and satisfy meaningful use, the facilities [LTC] have had no similar incentive or obligation. Thus, we have encountered numerous challenges and hurdles specific to these places of service.
Unlike office settings, we [physicians] don’t have access to support staff in nursing facilities to enter vitals, medications, allergies, lab results, and other data into our EHR. Sometimes we are asked to use the facility’s EHR rather than our own.
Moreover, the patients in PA/LTC settings have unique characteristics and care needs, but the quality measures developed for meaningful use were intended for patients in hospitals or in ambulatory settings.
Some basic requirements, such as e-prescribing and electronic communication with patients, are irrelevant or impossible to achieve in LTC.
Physicians’ practice EHR and the nursing facilities’ EHR often tend to be separate products with no interoperability and no functional interface.
... this program forces many physicians who are able to meet meaningful use requirements and receive bonus payments from their office practice to either forgo getting the bonus payment or see fewer PA/LTC patients to ensure they meet the meaningful use requirement and remain compliant with thresholds for meaningful use.
The “all or nothing” approach to satisfying meaningful use has led the majority of eligible professionals working in PA/LTC to seek hardship exemptions or accept the penalties.
Under MIPS, the majority of the measures remain ambulatory care–based, and physicians who see the sickest (and the most expensive to care for) patients in PA/LTC settings will continue to lose ...
Unfortunately, to date, much of the focus has been on various specialty societies, and PA/LTC residents and professionals who see them have been an afterthought.
Using EHRs in Nursing Homes: Avoiding Unnecessary Pain

By Rod Baird, MS

Today’s Geriatric Medicine

Vol. 6 No. 4 P. 14

Physicians must adopt certified EHR technology and demonstrate meaningful use before October 1, 2014, or face a 1% reduction in Medicare reimbursement in 2015—but there are several obstacles.

Existing federal regulations require physicians and hospitals to use certified electronic medical record (EMR)/electronic health record (EHR) technology or face penalties. Many long term and post-acute care (LTPAC) facilities are implementing EHR applications knowing that the Centers for Medicare & Medicaid Services (CMS) is destined to extend the requirements.

There are compelling reasons for the CMS and everyone treating the LTPAC population to embrace the use of health information technology (HIT). These patients, whether short or long term, populate the most expensive 10% of all Medicare/Medicaid beneficiaries. Unfortunately, the implementation of LTPAC HIT can have unintended consequences.
From a medical record perspective, each resident is three patients: the facility’s, the attending physician’s, and the LTC pharmacy’s. All three providers are regulated, and each must answer to a set of policies and procedures mandated without consideration of respective needs in a “shared” electronic record environment.
Under state medical board regulations, CMS reimbursement rules, and tort law, physicians are required to maintain a clinical record for each patient for whom they provide care. This record must be produced on demand.
If the physician’s only record is maintained at the facility, subject to facility control, the physician may be unable to produce legally required documents on demand.
There are several examples of physician groups subject to CMS claims audits that were required to make audit repayments because the facility could not retrieve archived copies of records.
LTPAC facility software evolved to address federal and state compliance mandates of conditions of participation, MDS reporting, and documentation required to support billing and audits.
... software for the nursing home ... is not designed around the documentation needs of the LTPAC physician or extender. The entire concept is different. Facility software is built around the incredibly detailed CMS Survey & Certification process ...
Recommendations

• Full use of EHR in medication process:
  – Documenting / Ordering
  – Administration
  – Alerts
  – ePrescribing
  – QI/Reporting/Tracking

• No paper duplication
Recommendations, Cont.

• Connect to HIE
• Use of a Clinical Pharmacist consultant for transfers
• Include PA/LTC operators and practitioners in shared savings programs and align incentive programs under MACRA and the IMPACT Act
Resources

• Leading Age Center for Aging Services Technologies (CAST) 2015 EHR Portfolio (26 vendors):
  – Product Selection Matrix
  – Online Selection Tool
  – Case Studies

• StratisHealth Nursing Home HIT Toolkit
• HealthIT.gov Issue Brief (HIT in LTC & PAC)
• LTPACHIT web site
• MACRA impact article / EHRs in LTC article
• Geritech (blog by geriatrician about technology)