Urban Health Plan, Inc.

Electronic Medical Records

Alison Connelly, RPA / EHR
Project Manager

Introduction

- Background of UHP
- Selection Process / Contract
- Workflow Analysis
- Implementation
- Oversight
- Challenges
- Conclusion

Our Mission

With over 30 years of service and a deeply rooted foundation in the South Bronx, Urban Health Plan's mission is to continuously improve the health status of the underserved communities by providing affordable, comprehensive, and high quality primary and specialty care. Urban Health is dedicated to rendering care in a culturally competent, barrier free, individualized, and family oriented manner, with an emphasis on prevention through education and the provision of state of the art services.

Our History

- Founded in 1974 by Dr. Richard Izquierdo
- Federal Qualified Health Center (FQHC) designation in 1999
- Re-accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) in 2006
- 3 Sites
  - El Nuevo San Juan Health Center—1065 Southern Blvd.
  - Bella Vista Health Center—890 Hunts Point Ave.
  - Plaza del Castillo Health Center– 1515 Southern Blvd.

Our History

- 5 School Sites 3 Off-Sites
- One Administrative Site
- 2006—27,000 Users and 149,000 Encounters
- 82% Hispanic/ 15% African American/ 3% Other
- Largest employer in zip code 10459

Institutional Demographics

- ~370 Staff Members
- 60 FTE providers (~80 providers)
- Primary care (Adult/Pediatrics/OB-GYN)
- 16 Specialties
- 2007 Productivity Projections: Users ~28,000
- Visits ~150,000

Timeline of Events

- 1993 primary care initiative grant-NYS DOH- ended with a PMS (MSI)
- 1995 Logician- very complicated and we were not ready
- 1997-1 license EMR (PRAXIS)- nice system but we were still not ready
- 1999- Medical Manager PMS- very well thought out selection/implementation process

Time Line Cont.

- 2001/2002 OmniDoc from Medical Manager/WebMD
- August 2005 ~8 providers using OmniDoc- printing out notes- decided to change EHR system
- November 2005 purchased eCW
- March 2006 began implementation eCW
- September 2006 completed implementation of eCW

Initial Attempt at Implementation

- Began implementing modulars of EMR during 2002
- After 3 years, we were only writing prescriptions, viewing scanned images, and using a Summary Sheet
- Only about 8 providers were writing notes in EMR due to difficulty of use
- Time came to accept it wasn't going to work

Early Signs of Trouble We Missed:

- Difficulty installing system
- Unqualified / inexperienced trainers
- No project management from vendor
- Upgrades resulted in “system crashes”
- Vendor inflexibility
- No relationship with vendor

Early Signs Cont.

- System was difficult to use and not intuitive
- Unable to track patient flow
- No clinical decision support tools
- No flow sheets
- Should I go on??

How come we didn’t see the writing on the wall?

- We were EMR inexperienced
- EMR systems weren’t great or too costly
- Originally based our decision on $$ - thought we were getting a “great deal”
- We didn’t know what we didn’t know

What we accomplished with failure?

- Project team became better educated
- Exposed providers to EMR
- Secured Provider Buy-in
- Understood the difference between an integrated and interfaced PMS/EHR system
- Developed an understanding of what kind of vendor we wanted to deal with
- Helped our first JCAHO survey- problem list/medication list/surgical history/Quality Care Guidelines/Allergies/Hospitalizations

Overview of Second EHR Selection Process

- 1st step was easy- team was convinced of change including CEO
- Quickly outlined a list of vendors based on functionality
- Demo process
- Site visits for the top systems
- Selected system in ~10 weeks
- Signed contract ~14 weeks

New Selection Approach

- Same Project team- Project Manager,
- CTO, CMO,CEO
- Provider user group to view demos
- Created a must-have list of features- since we had experience!

New Selection Approach Must Have list

- Patient Summary Sheet/Medication list/Surgical Hx/preventive health alerts (JCAHO complaint)
- Templates
- Discharge summary
- Prescription system performs drug-drug interactions, formulary check
- Patient education for medication in English/Spanish
- Reporting tool- Health Disparities registries/UDS reporting
- PMS must be able to do FQHC billing in NYS

New Selection Approach Must Have

- Pediatric growth charts
- Ability to customize user views based on job function
- HIPAA compliance
- HL7 lab interface
- Decision support tools and clinical reminders
- Referrals- ability to track

New Selection Approach Must Have

- Ability to use drawings
- Flow sheets for OB
- Redundant servers
- PMS/EHR fully integrated
- The “would be great” features:
  - Electronic signatures
  - Bio-sensor technology authenticate patients and staff
  - Dental
  - Patient Portal

Process for selection of new EHR

- Multiple products evaluated
- VENDOR Qualities:
  - Viable company committed to CHC's
  - Company that will involve us in the future of the product and listen to our needs
  - Reputation for outstanding customer service (cold called existing customers)
- Chose the vendor first and the product second
- Site Visits
- Ultimately a visit to company headquarters to meet with owners

ECW EMR Cost

- Hardware
- Software – 70 licenses
- Maintenance and Support
- Training (including some lost productivity)
- Total purchase, training and implementation cost about $10K per provider and $2K per staff member

Other Costs to Consider

- Hardware in exam room (computer/laptop/tablet ,printer)
- Equipment that interfaces with EHR – such as EKG, Holter, Vital Sign machines

Implementation Strategy

- Project team-project manager, CTO, CMO, CEO
- Project Manager should have clinical and administrative knowledge
- Met with CEO and rest of project team on a weekly basis to discuss progress, next steps and challenges
- Negotiated contract with payment attached to milestones
- Discussed milestones stipulated in vendor contract

Contract Highlights

- Pay for performance based upon predetermined milestones
- Discussion if milestones are missed
- Trainers – selection/removal by customer (within reason)
- Software license fees - % paid upon contract signing and balance in increments as milestones achieved
- Support and Maintenance do not accrue until system live
- 24/7 Customer Support within 30 min of call

Workflow Analysis

- CRITICAL STEP!!!
- Flowcharted all processes that occur within the organization (from when pt walks into the clinic until they are discharged and all steps in between)
- Evaluated how workflow would have to change (EHR's not built for any one clinic/practice)
- Documented how the processes would work in an EMR world
- Trained the vendors trainers on ***how*** our staff needed to be trained

Implementation

- Migrated all demographic information, appointments, medications and immunizations from previous system
- Pilot Site March 2006– Bella Vista Health Center
- 8 exam rooms
- 1 physician, Nurse Practitioner, Physician Assistant, Part-time GYN/Podiatry, Nutrition, Social Services

Implementation

- 5 medical assistants, receptionist, part-time medical records clerk
- ~10,000 patients visits/year
- Almost forgot about others affected by Bella Vista going “live” – call center, diagnostic department, referrals department
- Training – Providers 3 four hour sessions; Medical Assistants/Receptionists 2 four hour sessions

Implementation

- Templates reduced by 50% for 1st week – after 1 day, providers wanted schedules re-opened
- Supported clinic on-site for go-live week
- Rollout continued as follows:

Rollout

Plaza del Castillo Health Center	April 2006
Urology	April 2006
ENT	April 2006
Begin development of Lab Interface with Quentin	April 2006
School Health (5 sites)	May 2006
Specialists (Cardiology, Endocrinology, Rheumatology)	May 2006
Pediatrics / Adolescent Medicine	May 2006
Nutrition	May 2006
Social Services	May 2006
Eye Clinic	May 2006
Walk-In Clinic	June 2006
Surgery	June 2006
Adult Medicine	July 2006
Ob/GYN	August 2006
Begin testing of Quentin Interface	August 2006
Psychiatry	August 2006
Gastroenterology	September 2006

Implementation - Lessons Learned

- Implementation was easy!
- Don’t make any assumptions about specific providers / departments or you may be surprised (ie schedules)
- Be flexible
- Modified training approach midway through implementation – creation of the “Hot Seat”
- Ongoing training and support
- Any deficiencies/inefficiencies you have are highlighted
- ***FUNCTIONAL BEFORE FANCY***

Just when you thought you were finished……Oversight, oversight and more oversight

- Scanning
- QA
- Peer review
- Waiting times
- Labs / documents to be reviewed
- Referrals
- Recalls
- Locking notes
- Staying in touch with departments to make sure old habits don’t pop up

Challenges

- Getting staff (and patients) accustomed to new environment
- Adjusting to and correcting newly discovered workflow inefficiencies
- Re-deployment of staff
- QA
- Assuring enhancements are completed
- Reporting
- Positioning equipment to maintain optimal patient care
- Ergonomic issues

Key Points / Conclusion

- First and foremost - Executive level support and commitment is key
- Engage providers and staff early on
- Improve provider and staff computer skills
- Product is important but the Vendor can make or break the project
- One EHR does not fit all – need to make it work for you (workflow analysis and redesign)
- Train the vendor on your workflow
- Good IT infrastructure

Key Points / Conclusion

- Maintain a “crash cart” for when system goes down
- Training is on-going and critical
- Dedicated project team
- New Employee Orientation had to change to incorporate a training component
- With upgrades come more training
- Identify in-house trainers early on

On the Horizon

- Biometric technology - Iris recognition to improve patient safety
- Enhancing registry reporting capabilities
- Interface with Dentrix
- Interface with PACS
- Building public health functionality into program (interface with CIR, enhanced Decision Support Tools)