Electronic Health Records: Why You Need Them and Where to Begin.

Welcome and thank you for joining us for Part One of the Three Part Webinar Series. Presented by Lori Nichols and Mari Dominguez.

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If you have a question that is not addressed in the presentation, we encourage you to contact Caitlin Hungate at the National Training Center for Management and Systems Improvement chungate@JSI.com and I will direct your questions to the presenters.

Ms. Nichols has more than seven years of professional experience working in health information technology. As a consultant at JSI, she has worked on a variety of health IT projects including health IT monitoring and reporting for the agency, for health care research and quality, as well as several pre and post implementation workflow in capacity assessments for clinic and health centers.

At this time, please welcome Lori Nichols.

Lori Nichols: Thanks, Caitlin. Hi, there everyone and thanks for joining us. We are going to cover a lot of ground today on some of the basics of EHR and then as Caitlin mentioned, we are going to have sometime at the end for any question and discussion.

If you can't hear me for any reason please use the chat function on your WebEx to let us know that, our overarching goals today are going to be, as we said to discuss EHR's. we are going to do that in terms of their core functions, as well as how they can benefit family planning programs. We are going to define some of the more commonly used EHR related term, we are also going to give you some resources some more information.

Ultimately, we were hoping that after today you're going to feel comfortable identifying not only some of the core functions and benefits but also some of the resources that are available to you. Also, some of the next steps that you're family planning programs could take, if you pursue EHR adoption and so with that, I'm going jump into a little bit of background information first.

So how did we get here in regards to EHR's. Way back in January of 2004 in State of the Union address, the President launched an initiative to make electronic health records available to most American's within the next 10 years, so 2014 is actually coming up pretty close here. We may not have gotten quite where he envisioned but we are making good progress.

He's quoted in that speech, as saying, by computerizing health records we can avoid dangerous, medical mistakes reduce cost and improved care. So then fast forward five years to 2009, President Obama reiterated government support for EHR.

He also mentioned EHR in his State of the Union address, when he talked about the financial recovery plan. He said, "a recovery plan will invest in electronic health record in new technology that will reduce errors, bring down cost ensure privacy and save lives". So with under his leadership that the health IT for Economic and Clinical Health Act, it's better known as HITECH that was signed into law as part of the American Recovery and Reimbursement Act.

The concept of meaningful use, the financial incentive was also introduced at that time and we are going to talk about that more in a moment. More recently, I believe it was March of 2010, when President Obama signs the Patient Protection and Affordable Care Act that also strengthened the HITECH Act because it gave us a more specific timeline as well as criteria for meaningful use.

In October of 2010, the final rules for Accountable Care Organizations came out, which also strengthen the need for robust EHR's by providing additional, financial incentives for (rural) doctors and hospitals. And then as all you know when the Supreme Court, upheld the ACA in June of 2012, by a vote of five to four. There was a move toward EHR that was against (inaudible) because lot of the items in the ACA, do support the transition to electronic medical records.

So 2012, also marked the time, I should note that when the providers in hospitals were entering what was known as Phase I of meaningful use, which we are going to talk about a little bit later in this presentation. So while there is not, well there you go. Well there is not a lot of research out there in EHR implementation within family agency specifically. I did want to note the study from the Gumacher Institute that indicate some of the areas in which publicly funded family planning centers, say they're not as well as prepared as they would like to be, in order to move forward with adopting EHR's.

I'm sure these are partly due to numerous, financial, technical and logistical challenges that the clinics and agency space and we will talk more about specific barriers in just a moment. But I also wanted to note, that although this chart you see at the bottom that it's referenced as being published in the winter, 2012 edition of the Gumacher policy review, the study that collected this

information was actually conducted in late 2010 and early 2011 and results were first published in spring of 2012.

So the information might be a little outdated in the technology role, but it's a starting point for our discussion. So you'll see that the graph shows different levels of preparedness that are reported in various areas such as if you look at the top staff experience within EHR, only 39 percent of the agencies reported preparedness in this area. And there is training capacity which followed very close to that with 40 percent feeling prepared.

And this refers to really having access to the internal and external resources that can be used for either initial or ongoing training within EHR. Staff, IT, literacy follow third with 47 percent and this really has to do with the staff knowing sort of the terminology and knowing the latest and greatest with IT and what we here sometimes, when we talk to clinics is, we don't know what we don't know and so feeling comfortable just in IT language in general was a concern.

Agencies have a little bit more prepared in the next three areas if you see, the graph that about America kind of shoots up a little bit. IT support came in at 57 percent, that's really looking at resources for ongoing maintenance, troubleshooting, upgrades, things like that for the IT structure. The infrastructure came in, very close as well at 59 percent that really refers to the hardware and the equipment needed to successfully support in EHR.

And then the internet access or the connectivity issue came out, as the area where agencies felt them most prepared and that the response rate is 73 percent. So now we'd like to take a moment to hear from you, regarding some of these factors. So we are going to use a polling feature at the side of the screen to respond and what you can do at this point. If you're joining us on the phone and you actually don't have access to the webinar.

Just stay there with us for just a moment, for those of you that do have the webinar in front of you, you can respond to the question, which of the following components, do you feel you have in place to embark on adopting electronic health records? We will wait for just a few moments, for folks to respond and then we will get to see the results.

Couple more seconds here, we are seeing the results coming in. yes, we will go ahead and close the poll in three, two, one and it's closed. OK, it's giving us another 15 second here. I can talk a little bit some of the response, can the respondents see the (samples) as well. OK, so it's really interesting to me, how this are shows up as a graph and it really mirror's the graph that we just saw on the slide.

With people feeling most prepared in terms of interest access and connectivity and lease prepared with staff experience within EHR. So thank you for taking the time to respond to that.

We are going to move on to some EHR terminology. And as you know there is lots of acronyms out there that are used when talking about EHR's and I know the one, I started in the field seven years ago.

I felt, like I had to learn a whole new language. We won't have time to go to all the possible abbreviations that you might come across but I wanted to hit on some of the highlights. So first and foremost, I wanted to bring up the fact that we are using, intentionally using the term electronic health record of EHR, in this presentation and most of the time. This term is used, interchangeably with electronic medical record or EMR.

Given that the goal is to exchange health information using some kind of technology. However, you might see a slight distinction made in the literature. So I wanted to point it out here as well and that is that, the EHR is the most comprehensive concept because it applies to the information that is shared between providers and across facilities that it could be made up of, information from various EMR's.

For example, your dentist might have an EMR and technically they would call, their EDR, because it's an Electronic Dental Record but it serves the same purpose and that can provide data to your health center's EHR system. Likewise, you've got labs and pharmacies that might use an EMR system and that can also feed into the EHR. So in either case, these are records that are created and maintained by the organization.

There is something different, that's called a Personal Health Record or a PHR and that could be created by the organization or could be created by an individual and just kept on a flash drive. It's completely maintained and controlled by that patient, so it's very different. Other commonly used terms include Health Information Exchange or HIE. This one's pretty straightforward, it just refers to sharing electronic health related information, but under very specific privacy and security with those security factors in mind.

The Office of the National Coordinator for Health IT is commonly referred to ONC, this is a position that is within the Department of Health and Human Services. It was created by Executive Order in 2004, in written into the legislation that's in the HITECH Act that I mentioned earlier. And the ONC's purpose is to promote a National Health Technology Infrastructure and to oversee the development of that structure.

And last but not least, we have certified EHR's and well this isn't really an acronym, it is short-hand for referring to specific EHR products that have been approved by the ONC. These are ones that need the level of standards and criteria, particularly those required to help providers demonstrate meaningful use of the technology and we will talk about meaningful use now.

So what is meaningful use you see might wonder. The Centers for Medicare and Medicaid Services, otherwise known as CMS has these Medicare and Medicaid EHR Incentive Programs that provide financial incentives, what they call meaningful use of certified EHR technology to improve patient care.

This is demonstrated by meeting threshold at CMS, has actually established and there is a number of adjectives for those eligible professionals you'll see here in parentheses, it says EP's, that's term that's used when discussing meaningful use and it refers to how CMS, define who is eligible to apply for their financial incentives. So that's going to come into play a little bit later in our conversation.

I should also note that, each state or territory offers the Medicaid Incentive Program voluntarily, so you might want to check to see, if you states program is active. The last time I checked, there were active programs in all the (season) territories except for five and those were D.C., Hawaii, Minnesota, Nevada and Virginia. If you're interested in learning more about meaningful use specifically.

I will mention, there is a future webinar planned for June and that's going to be devoted to this topic and I believe that there is going to be updates available on the National Training website that Caitlin mentioned at the beginning. So what exactly are EHR's. I think that some of us, if not all of us can relate to the picture on the left and in the most basic sense.

EHR is really a shift away from the paper charts that can be hard to find, they can be challenging to update. Sometimes, they're hard to share with other healthcare providers and really moving towards a real-time, patient center record that's complete with the demographics, that's got the problem list. Medication list, history and all kinds of other stuff.

So some of the most fundamental benefits of EHR's are that health care teams can access the information, when and where if needed. There is often the ability to use the EHR capture external documents in a record like your labs, your pharmacy, your radiology and dental records and if you, specify it to your particular needs. It can also be designed to include care plans, guidelines and protocols.

And last but not least, the EHR can help provide patient specific instructions that can be very easily printed out for the patient, which is a really nice advantage. However you might imagine, there are lots of consideration when deciding on what type of helps that cause IT to implement in your settings. So here we've listed some of the key considerations, but they're not in any particular order.

All mentioned them from top to bottom. But they're not listed, they're not prioritized in that way. So functionality versus usability. This really refers to the fact that, vendors will tell you, yes our system can do xyz that's getting up the functionality piece, but there is an equally important aspect, which is to know how the user has to work with system and that gives up the usability piece.

So for example we've heard from clinics that, they were told that their system could perform a particular function, but then the reality is that the steps are so cumbersome that they don't actually use that function, so that's just one reason why, it's good to really have input from all of those involved with the system, anybody who's going to be using the system particularly the clinicians, when you're selecting a system and to also allow lots of time, to demo your system and actually see it in action.

Moving on down the list, we've got accessibility considerations and that might include who have access to what data and how you can give user rights to certain information, there is reporting which refers to what the system can provide for you to help me to reporting requirements because obviously you want to give, as much as you can out of your system in terms of the information and then other considerations include, what the implementation process would look like for your site, things like the timing or the duration of it.

Whether you would start with one provider at a time, I have everybody start all at the same time that kind of thing. There is also considerations like, what kind of training and technical support is available and that's both at the beginning as well as ongoing. And of course is important to consider what the disaster recovery plan or in a more positive framing the backup plan would be, in the event that your server rooms is on fire or some other crazy events happen.

And lastly, a key consideration would be how to maximize the ability of your system to give complete confidentiality security to your patient. So I know that those considerations can sound a bit overwhelming but I wanted to take a moment to think about some of the limitations of continuing to live, with a paper chart system. So if I took a poll in this slide, I would guess that most of you would say, that keeping check of paper charts can be difficult for a number of reasons.

You know, even under the best circumstances paper charts can be misplaced, this cause the staff to have to spend a lot of valuable time looking for charts. Another disadvantage is that only open person can have a paper chart in their possession at one time. So it's very different than having multiple staff be able to view in electronic chart simultaneously. So when a paper chart is going from one staff member to the next, there can also be delays and frustrations well somebody is leading for it, to get from point A to point B.

And even more frustrating to finally get the chart and then finally you cannot read the handwriting that's in it. Likewise if the information isn't organized well or if it's not consistent. I know that in my experience different clinic providers like to organize the chart in different ways and sometimes they have a hard time agreeing, you know which section should come first and that could make it really hard to quickly find the information that you're looking for.

And when looking for that information, that's also possible that the most current information has not even made it into a paper chart for a few days. On the Office (inaudible) you can picture some of your patients, who've been there for a long time, they can have really (bad) chart. The oldest information's, might may have to at some point be archived. Simply because of the physical limitations of the space within that chart, so that's another limitation.

And then last but not least, as you saw in our picture. A few slides back that the file room themselves can be a little overwhelming, they can pick up a lot of valuable space especially in some of the smaller clinics and the time that it takes to file paper chart can be very consuming. So if we think about these limits and compared on what the potential benefits of EHR, here we go, thank you.

Those include the ability to exchange information with partners like your labs, your pharmacy, your specialist, mental health providers and I'm sure, lots more partners as well as the ability to monitor your performances at different points in time, to use the data to inform or support your quality improvement program, to produce reports for your stakeholders and then to also take advantage of clinical decision support tool.

All right, sorry about the technical issue on our side, we will try advance our slides. So most of the advantages that I just mentioned, were benefits to the organization but listening from moving about benefits to that are more specific to the patients. Such as the fact that our comprehensive record can give the health care team more information and I think all of us would agree, than when we are the patient, we want the folks that are taking care of us, to be as knowledgeable and competent as possible.

Another big benefit to patients is the improved privacy the EHR's can provide. You know we often here, initial resistance from patients who think that with EHR's are private information, is somehow is floating around in cyberspace. Ironically most people don't think twice about using an ATM and having their financial information being sent over the wires. So I think that, when we can explain to patients that passwords and things like encryption standards are in place to allow only the right people to access the EHR and that tells us exactly who, when and how someone access their information.

They too will see that EHR's can protect their information in a much greater way, then locking up a file room or locking up a desk drawer. So now that we've brought up some of the benefits to organizations into patients let's talk about the benefits to the family planning providers in particular and the good news is that, there are several benefits. So first we have found that, EHR's can help automate and streamline our providers work flow, allowing for more time to be used efficiently and productively.

And I've never visited a family planning clinic that was not incredibly busy. So the one caveat that I have to add though, since I do work on clinic efficiency projects as well is that provider should closely examine their work flow before automating it. You want to make sure, that you're automating a good system and EHR's will not fix a poor workflow. Secondly, a big advantage to automating your information is being able to look for patterns or trends in regards to preferences, behavior and health indictor.

So this could be anything from your client scheduling preferences. It could be, about what services or family planning methods are being requested most, it could even be details about specific health problems that your clients are experiencing. Another significant benefit is that, EHR's can provide evidence or excuse me, access to evidence based tools that can be used in supporting your clinical decisions.

So these are referred to as PDF tools and that stands for either clinical decision support or depending on the source that you're looking at, sometimes it's worded as computerized decision support. These are tools that can help identify things like drug interactions or potential diagnoses. So additional benefits that we wanted to mention have to do with being able to share the information quickly with your partners, we mentioned that few slides back as well as having quick and easy access to accurate and timely information.

It also provides a way to report back to your stakeholders on clinical outcomes and help support the documentation that you might need to seek reimbursement from payers. So earlier we mentioned, that concept of meaningful use, that the federal incentives to adopting EHR's and if you're wondering why family planning programs, should care about meaningful use, I will give you some good news.

There is a couple important things to know and while you may have heard, meaningful use applies to hospitals, it also applies to that term that I used, which was eligible professionals and what this means, is that you might have multiple providers in your organization, who could tap into these incentives. So one of the critical components of being qualified as an eligible professional, is that the provider must show that at least 30 percent of their patient population is enrolled in Medicaid.

So if that's difficult for you to think about right now, think ahead about Medicaid expansion as part of the ACA and very well, could help providers meet this criteria and could directly impact how many of your providers, might be available for that incentive money. So the Medicaid incentive program is voluntarily offered and as I mentioned earlier. There might be a few states, who are not actively participating.

So you want to check for your particular state, but the best part is that it is not too late. The meaningful use program was designed to offer six years of financial incentives. It's scheduled to be in place through the year 2021 and so what that means for you, that as long as you adopt the technology by the year 2016, and can demonstrate meaningful use of the technology, you can still take advantage of the funding.

And it's not a small amount of change, we are talking about $63,750 over the course of the six years, the way that breaks down, the first year is a much larger sum, somewhere around $21,000 and then the subsequent years are about $8,500, but over the six year time span, it does equal to that $63,750 amount. So this provides a great financial incentive to doing, what you're already doing, which is positively impacting patient care.

So how is ONC and CMS helping to pay the way, for EHR's well encouraging the use of a certified system is a great place to start because that way you know, at least you're getting your system that meet all the requirements that support meaningful use and in addition, there is a lot of focus being put on standards and security right now, which is really important because of common set of standards, is what's going to be needed for EHR's to exchange data with each other.

So just to review, some of the benefits of using an EHR, more comprehensive record for being not limited to one organization and not limited to the space limitations in a paper chart. Secondly, that EHR can facilitate space and secure sharing of information, whether that's within your organization, across organizations or even between organization and patient. EHR's can automate and streamline the workflow and again, I will mention that caveat that a pre-implementation workflow analysis is a key step because automating a workflow that is not working well for us, is simply allowing a bad process to go faster.

And then another benefit is having that clinical decision support tools at your fingertips. And so if you're not convinced yet and you need more reasons to jump on the EHR bandwagon, EHR can give you the ability to look for those trends and patterns and your patients that I mentioned, this can be done through a patient registry component of your EHR or through other reporting features. You're going to have that data that's available to help facilitate reimbursement from payers.

And whether you're implementing now or in the very near future. You've got that opportunity to participate in the Medicaid incentive program a meaningful use and last but certainly not least. You can use the information in your EHR to help improve patient outcomes. So if you're thinking about getting started, you want to consider the benefits. You want to consider how to maximize them.

But you also want to consider the challenges and how best to overcome them. So I'm thinking about the challenges, I wanted to provide a little more data, it's from the same Gumacher study that we referenced earlier. This one indicates the concern among the family planning programs to our survey, so at the bottom of the list, you're going to see that implementation cost were rated as most problematic.

This was followed by the ongoing cost and the acquisition cost. There were other concerns as well, they're not rated nearly as high on the problematic scale, but we wanted to include those. So things like accessing IT support, overcoming resistance from clinical staff and overcoming the concerns about patient confidentiality. So here's another opportunity for you to let us know your thoughts.

We are going to use the polling feature again, at the side of your screen and for this one, you're going to want to tell us, which one applies the most. So please tell us, what most concerns you and it's going to either be cost, IT support availability, resistance from staff or concerns about patient confidentially. Please select your top answer. We will give it about 10 more seconds, all right five, four, three, two, one. We will close the poll. It's going to wrap up the responses here and again, everybody can see what we are seeing. OK. We are almost there, hang tight for just a couple more seconds.

All right, now can see the results. OK, great. So overwhelmingly, we see the cost is a big issue information technology and (resistance) from staff came in with a few responses and no concerns about patient confidentiality so that's huge. So I think, if I done this poll, a few years ago that chart would have a looked a little different, we were hearing a lot about patient confidentiality concerns in it, it's nice to see that the tide is shifting on that.

Great, thanks for that. Let's see OK, moving on to how to breakdown some of the barriers. So obviously the financial barriers are not insignificant. They shouldn't be taking lately, but the good news is, there are some financing options out there. If you're willing to get a little creative. So sometime those do, they do offer leasing options. So that can help spread the acquisition and the implementation cost out, so that you don't get hit with everything at the start of your project.

Likewise, there is systems that can be implemented in using what they call deliverable based payments, so that's just another strategy to spread out the payments a bit for you. Other

strategies include clinic looking for grant making foundations and your state for either the software or the hardware grants. And if you're fortunate enough to be able to time your selection and procurement process with other similar organizations.

You might be able to leverage this, to get some kind of group purchasing discount as well. So just one thing to think about, to help tackle the obstacle that has to do with accessing the IT expertise particularly for those of you, that are in smaller and more rural communities, where personnel resources can be a challenge, this is another opportunity where you can pair with another organization, maybe one that's larger than your own to help identify an ally or a mentor that's already gone through the process.

And I know that some of the rural organizations here in Colorado have also shared IT resources between them. You could try contacting your vendor to see if they know of super users in your area or other IT support in your area and there is a couple of online resources that we wanted to be able to provide for you. One of them is on the ONC website, it's this EHR implementation lifecycle.

It offers a lot of great resources that have to do with six steps in the implementation cycle. So it's everything from accessing the readiness, planning your approach, picking or upgrading your EHR, if you already have one. Training, implementation, achieving meaningful use and not supporting the quality improvement initiatives.

There is another great resource out there and that's on the (personal) website, its' the health IT adoption toolkit. It provides a lot of information, it's divided into topic specific modules, so there is for example, there is a module just on financing, there is one just one staffing. There is implementation, there is change management, there is very what they call special topics on personal health records and e-prescribing and things like that.

So it's a great place, if you want to go check it out for some more information. Moving on down the list, of the most common concerns there were, the concerns about patient confidential obviously didn't come up as a big one here. But I just wanted to mention that they are being adjusted. The ONC certification process, that process really takes into account not only the technological capabilities and functionality but also the security of a system before they certify it.

Last time, I looked there was an over a 1,000 certified EHR's out there. So you certainly are limited when you're picking from a certified list. And then last but not least, breaking down cultural barriers. So this really requires soliciting and leveraging the support from your leadership, leadership in the organization really goes a long way to sort of setting the tone, within the organization and then as I mentioned earlier.

Obviously automating a bad process is in nobody's best interest. So doing some kind of workflow analysis, it helps to get people excited about the change. They get excited about making improvements and increasing efficiency. And readiness assessment and training that also helps the organization get ready for the transition. It helps the staff get more comfortable with the changes and people are generally more excited about the technology when they feel confident, that they're going to be able to use it to its full potential.

And then, when it comes to change management, communicating early and often with your staff, with your patients and their families that really goes a long way in garnering support and breaking them the (sphere) of the unknown. And lastly having a solid migration plan. How you're going to go from paper to EHR is essential. Some clinics really spend a lot of time on the front and scanning in old records for example.

And others take the route, they enter their patient's data just as they come in, so the next schedule visit and there is really no right or wrong way, it's just your way. So as long as we have your plan, you're in good shape. And now I'm going to hand it over to our next presenter. We are going to hear more about some real life choices that you could face with as you go down this path, so please join me in welcoming Mari Dominguez to the presentation.

We are so fortunate to have Mari on the call with us, she's got more than 21 years of experience in family planning. She's the Executive Director at Bridgercare which is a Title X reproductive health clinic in Bozeman, Montana which is a beautiful, I've been there. As the Executive Director at Bridgercare, Mari oversaw the implementation of EHR system very recently, it was just in 2012.

She is a registered nurse and received her degree from Montana State University in Bozeman. So with that, I'm going to hand things over to Mari.

Mari Dominguez: Thanks, Lori. I'm happy to be with you today and hopefully I can share a little bit about our experience that will be helpful to those, listening in on the webinar. To give you a little more information about Bridgercare, we are 41 year-old Title X clinic in Bozeman as Lori said, Bozeman is a town of about 40,000 and the surrounding communities in the county give us kind of an extended population of just under 100,000.

We see about 6,000 unduplicated patients a year at about 9,000 visits per year. Our largest patient demographic is 18 to 24 year old and then our next biggest group is 25 to 30 years old and about 10 percent of our patients are men. The other healthcare venues in Bozeman that are similar to Bridgercare would be our community health clinic, and it has a locations right in Bozeman and some surrounding communities.

And there is also a student health service at Montana State University which is in Bozeman and they see a fair amount of patients for reproductive and related health care as well. We chose to implement, the EHR system for a variety of reasons. Specifically this one, that we wanted to increase our efficiency, we were trying to be proactive in the phase healthcare reform and also the changing landscape of Title X.

So we felt that the staff time, we were using to process and manage our paper chart was hindrance for us and that was our biggest reasons. Some others reasons were that, Bridgercare had used electronic practice management system for about almost 15 years prior to our EHR implementation and those were used primarily for patient demographics, billing, insurance billing and gathering data for (CBR) submission.

And we were unhappy with the software we had for that process, so we thought if we need to make a change to our EPM's, to soon maybe now would be a good time to look at EHR. We did have funding and reserves for this project, so that was a motivator and we also are hoping, we have not yet, so we are hoping to access meaningful used funds that were a reference earlier. So as I said, we funded our EHR system through reserves.

So over period of probably actually about 10 years, Bridgercare had implemented income verification under Title X guidelines that had enabled us to better distribute our patients probably more accurately and based on Bozeman's financial demographic across or sliding (fee) scales, but we did have healthy reserve that are (forward) in leadership or committed to dedicating to EHR and we long-term saw that, almost a capital investment in our organization.

So we felt that this was really, a trend in healthcare that we couldn't ignore, that it was the right time for us to, go ahead and get started. How we made the HR happen, we have been using for a little bit over a year, almost a year and half. We started in November 2011, struggles and setbacks in our implementation.

I would say, our biggest individual struggle was our staffing demographic and as many of you're aware. There is sort of discussion in the Title X community about the (graying) of our healthcare provider staff in that, many of our mid-level providers have been working the Title X for a long period of time and they have a lots of experience, but conversely they're less technology experience and perhaps some younger healthcare providers that have recently come in to the U.S. healthcare.

So our staff of seven providers, one provider had previously worked within EHR system. But none of the rest has, so that was a challenge for us. In conversely, our support staff would use primarily use our electronic practice management systems or much more experience and also just

demographically younger and I think, you'll see in this process. It is true, although not always across the but board but generally younger people just have a much higher comfort level with technology and learning.

New technology in software, it's just less of a cliff for them, to feel like they're potentially going off. So that can be helpful for you just gage your demographic and plan for it. It doesn't mean you can't doing EHR with you know, an older staff, but you just will have to I think make plans more for how people learn well, what's going to increase our comfort level, you want that to figure into your timeline, as you make your implementation plan.

How we alleviated challenges was exactly a few slides ago, Lori mentioned but we communicated with patient so as we started our transition. We are posting, please be patient with us as we learn new process. We had (bowls) of (candy) which probably weren't great from the healthcare standpoint, but we knew we would take longer in the first few weeks of using it.

We planned for longer patient visit, we planned in our budget for probably seeing less patients in the year that we implemented for that purpose. Still communicating and planning I think are probably overall things you can do to help alleviate some challenges. Our EHR system, has helped us in lot of ways, some I think we anticipated in some not, so much. Definitely the amount of times, that we are not utilizing define charts, to get information in the charts to out figure facts, records that need to go out, is significant and that was a hope that we had in going through this process.

Kind of an unexpected (zone) and a significant one is that, our receipts from processing health insurance having increased by at least 50 percent. It hasn't probably been long enough period of time for us to see how this will settle out. But it's significantly greater and we think that part of that is, our software flow, really requires every patient encountered to you know, just check in the patient as to whether they have Medicaid or insurance that we can file, you or consciously having to attach or not attach insurance through an encounter.

The billing is electronically exported and we use the billing clearinghouse. But I think we didn't realize, just by virtue of the fact that, those (clinicians) are built into the flow that software that I think we have captured more patients with insurance than we previously did it. There are probably some other reasons for that increase namely more patient staying on their parent's insurance policies longer with healthcare reform.

And probably some increased coverage, of (contraceptive) and preventive care. So I don't think, it all belongs to HR, but insignificant benefit. Also our clinical documentation is more uniform, it's easier to spot when we made omission. You know as you know, sometimes we have clinician to sideline as beautiful (inaudible) and that's an amazing skill, however the purpose of

documentation as you know and you're studying is to manage risk and to document the work that you do.

So you want to do that thoroughly enough that, it is adequate documentation and no more than that really because that's not the function of what you're doing. You're doing healthcare and you need to document it, but documentation of your healthcare isn't the purpose to be at work. So I think, just for EHR, function is definitely streamlined out for us. My advice for clinics would be, to (shot) for systems.

So all these software companies have salesmen and you should access them. Have them demonstrate the software, ask lots of questions. Call them back and be very upfront that you're shopping mode, you're not ready to make decisions but you really want to get a good sense of how the software work. In that same (vein), you definitely want to get references so just like any major purchase you would make.

If you are hiring IT support, in your implementation and with your software. You want to contact other agencies or providers that are using the software, what are the pros and cons, what are they like, what seems difficult? If it's all possible and you can go to healthcare site that is using the software you're considering, it will just help you to visualize the process that you need to transition.

So you can see how the providers are doing, on call work or follow-up work or medication refills, all those things that are part of your patient care that will be impacted somewhat by changing the mechanism by which you document the processes. And that may not always be the case that you can access somewhere but it's sounded that all possible above and beyond just talking to people, who are doing similar work to you, that are using that system.

That'll be very helpful to you consider, what to do, I might choose staff. I would encourage you to identify the early adopters, so they may not be the youngest (staff) necessarily. But you hopefully know your (staff) and if you don't, they're likely tools out there to help you asses, who isn't intimidated by change, who is good at software, who has used different software's because you're going identify those key people and help them get comfortable at the software quickly and then strategize with them as to how they're going to help you, help the rest of you staff.

Depending on the size of your staff, if you're going to need key people at all places in your settings amongst your clinical staff, the clinical support staff, out to front desk of the billers. And there is no way one person, one or two people even can be that. So in all those areas, you're going to want someone who learns quickly and we all or fortunate to have those people, but you want to identify them, empower them, help them figure out, how they can help the rest of your

staff and identify them to your staff as people who are going to be there, to help them, who are little more hesitant, as you go through this change.

I think the other things Lori, alluded to that I would advice, which is try to partner with another agency if at all possible. It's just helpful to go through the process with someone you know is in the same boat. You just have more people feeding into the decision making and the problem solving and within (reason) initially you'll have a better outcome.

You can look at agencies in your community, that are using HR's, if you work with them a lot, you might want to consider looking at the systems they use, there will be clearinghouses set up for the exchange of information, so that people you know these different systems will ultimately be able to communicate, but one of our, one of our factors in our decision, to use software we did, is that our local hospital adopted it and so did the community health clinic system.

So that definitely said into our decision, you know wasn't, a tipping point necessarily but it was a plus knowing that some local agencies that we communicate with frequently, you had the same software. In other words I think just being as realistic with your time line as possible, planning for any big change like this knowing that, there will be unforeseen glitches, your benchmarks will take longer in most cases, then you anticipate.

But if you threw a plan for some flux time, in your timeline and then also in your daily process. I think you'll make the implementation much more doable and lastly, I would just say with any big process like this, when it seems overwhelming remember that there are steps and you're doing the first step, which is gathering initial information and you really just need to kind of chew through, each step as you're at it and eventually you'll be on the other side.

Lori Nichols: OK, thank you so much. Mari, I loved all of the suggestions that you have for the advice and I'm sure, it resonated with a lot of folks that are on the line. One of the things, that I wanted to add, to something that you said about identifying your early adopters. Something that we have found in some of the smaller clinics and Mari alluded to the sort of generational (divide) that there might be when it comes to EHR is that, it's important to identify those folks are going to be very enthusiastic.

But it's also important to identify folks that are, the most resistant and whether you pair your, your most enthusiastic person with your most resistant or how you want to handle it, but what we've seen in the clinic is that, when they can see that the person who started out the most resistant, finally makes that shift and comes around its huge for the clinic (inaudible). People have that mindset, of you know what it's he or she can change, then so can I.

And if he or she can get onboard, then what's my problem? So I can go along, well you also mentioned Mari, the onsite visit. I wanted to mention that as well, we have seen entire teams of people and again that's not always feasible for many reasons, but if you do have an opportunity to do an onsite visit and can bring multiple folks. So somebody who's going to interact from the billing side.

Somebody from the clinical side, somebody from the admin side sort of getting a well rounded team, to go and look at the software that's also very helpful. And then obviously the realistic timeline is a big one as well realizing that productivity is going to take a hit, for someone on a time. No matter how you plan it and being prepared of how to handle that. So we are going to open it up to questions in just a moment.

But before we do, I wanted to close with some other resources that might be helpful to you, if you implement in the HR for your organization. so one great resource is, it's merely available, it comes from something called regional extension centers or (inaudible) known as (REX) and they're located in every region of the country. They're received approximately $677 million inside of real funding for two year period to support their work.

And the great thing about the (REX) is that they're designated to provide on the ground assistance. They help, what they have defined as priority, primary care providers and what that means for them is going to be individual and small practices of either 10 providers or less, they support community health centers, primary health clinics, rural health clinics and then any other setting that predominantly serves under insured, under insured or medically under-served population.

Their services, just want to go, thank you. Their services include outreach and education, EHR support, such as working with the vendors, helping choose one of those certified systems that I talked about, they can provide technically assistance in implementing the technology and also using it in that meaningful way. They do have free or discounted fees that might apply to their services.

So what you want to do, is contact directors in your area, to find out more about specific services and any associated cost. So on this slide; you see that we provide an easy link to use. If you want to look up your designated Rex using your zip code follow the link that we've provided. Some additional resources that we wanted to make sure, to give you include the ONC and that's a great source for information related to either the Rex or EHR implementation in generally.

CMS is a great source for information regarding meaningful use. Obviously we've got Bridgercare on the phone with us today and talking with us about, what they've gone through and so they're great resource and Mari said, she's open to people contacting with questions.

Thank you, Mari and then Planned Parenthood is Utah's another one, it's one of the first family planning agencies I believe to implement in EHR.

So they are great resource and of course, please use your colleagues in the Title X world, who maybe at different stages in their planning or implementation and then as well, there is the family planning, the national training website that Caitlin mentioned as well. So that wraps up the formal part of the presentation. We are going to open up the phone lines for questions and discussion.

But I just want to thank you for your participation today. The slides from this presentation as well as the information about future presentations will be available on the national training website. The next webinar in this particular EHR series is going to focus on embarking on EHR, I believe that one is scheduled for April 23rd, if you want to mark your calendars. The third webinar in the series is going to focus on meaningful use as I mentioned earlier, that one is scheduled for sometime in June.

And so with that, I'll open it up to any questions that you have for either or myself and if you don't get your question, answered here. You think of something later, that you want to ask, you have Caitlin's contact information on this slide. So please feel free to direct any questions or comments to (inaudible) your convenience. Thank you.

Operator: At this time, If you would like to ask a question. Please press star then the number one on your telephone keypad. We will pause for a just to compile the Q&A roster. There are no questions on the phone line, I'll turn the call back over to the presenters.

Lori Nichols: OK, great. So there is a few questions that we have in the queue on the chat function of the webinar. So I'm going to take, one of them. The question is, has there been any studies that have looked at how long it takes to become more efficient. What I hear from providers is that, I have slowed them down, (inaudible) more efficiency and I don't know the organization, but it came from somebody named (Mary).

So that is a very good question and not an easy one to answer. There haven't been any clear studies on how quickly takes to get back up and running to the productivity level that you had prior to implementation. Mari, might want to speak to this in terms of her own clinic. We have seen like I've said, there are sort of different approaches that people have taken, when it comes to implementation.

So one of things, I believe I've mentioned in one of the slides and I'll speak a little bit more about it. Is this, approach of having for example one provider at a time implement. So you've got everybody else up and running at full productivity and you take one provider, you cut back

on their patient load for whether several weeks or couple of months until they can get comfortable with the system.

And that speed and that comfort level is really going to depend on the individual. So that's why it's really hard to sort of give you, a magic number for how long that will take. Other clinics what we've seen, if they don't do one provider at a time, they could go with a percentage of patient. So for example, they say we are going to go live on April 1st and we are going to see 20 percent of our patients on the electronic health record and the other folks were going to continue to do paper charts for a while.

So that allows the providers to cut back on their productivity slightly but not quite as much as if you went live all at once for everybody on the same day, that can be a little nerve wrecking. Mari, what would you say in terms of your clinics experience with productivity and how long did you feel the pinch after you had to cut back and are you back up to where you prior to implementation?

Mari Dominguez: Well, I would say, the comment that questioner provided, I have heard and you know I'm not (inaudible) back this up, but I think sometimes that's the comment, that is out there in healthcare community from providers who don't like, electronic health record and they're kind of wanting to bolt through their case for that they're really not efficient.

We increase the amount of time, we had allotted for appointment for actually six months, we dialed that back during that six month period and I would say, by nine months we were back up to our, to former speed and we were going through some efficiency processes during this time, which probably was not I'm sure the best strategy, but it was sort of like, while we're fixing it all now.

And as Lori said, EHR isn't going to fix the bad process. So I think, one thing that's really helpful for everybody in the clinic if you're looking at prior efficiency is to track visit. And when you do that, you often find the time, things are not where people are thinking they are, and efficiency is not that easy to see, especially if you're seeing patient. So you know sometimes everybody thinks, all the patients are (late) and then you track visits and you go, well no our patients are not late.

That's not where we're, that's not where we are losing time here. So I think tracking visits is helpful and also I think, is a good question because trying to provide users with actual data or empirical evidence will be helpful because you'll have the people who want to try it out, well I heard this other practice, went through this and these terrible things happen.

So if you encounter that with, hard facts that can be helpful.

Lori Nichols: Great, thank you and I love your reference to providers thinking that, their patients are always late because I have actually done a fair amount of patient tracking and we find that, in family planning clinic. Patients are generally more on their early side than on the (inaudible) side, so you're right that's not always contributing to the lack of efficiency.

There is a related question that has to do with return on investment. The question as it stated, says how do you get the return on investment to share record? So you know I think, as you can tell from my answers on the first question is how to measure, the return on investment, is very hard. If you're back up and running after about six months or nine months to your pre-implementation efficiency just in terms of sheer quantity, how many patients you can see.

That's one thing, but it's also how you can be utilizing the rest of your staff after you've implemented. So you know, Mari mentioned that, there is a lot of time stage on the back and people that aren't having to look for charts anymore and file and do that kind of things. And so you know that's one side, but there is also the incentive money. So the meaningful use dollars, I talked about when you're looking at per provider.

You know depending on how many providers, you got in your practice, that's also going to factor in to the ROI calculation about to see, at what point would you breakeven and do you even breakeven or do you consider it an investment and patient care and you know well financially, it is an investment on your part. It's very hard to measure. So participants can look at their clinic efficiency compendium.

It's on the National Training Website, we can provide the link to folks after the presentation, but t hat's going to be a great source to also just look at some of the rates of how many patients, you can be seeing or should be seeing, whether it's paper chart or electronic charts to kind of see, what your target would be. All right, let me see what are the questions we have here. There was a question here, I'm curious to know what Bridgercare is using for their EHR?

That question came from somebody named (Laurie), I don't have an organization name.

Mari Dominguez: WE are using (inaudible). We are using (NextGen).

Lori Nichols: Great and then, looking at another question. We have a question from somebody named (Randy) were you able to get federal Title X, required paper work, into the EHR without much difficult. So that's a question for you Mari.

Mari Dominguez: I'm sorry, can you say that again.

Lori Nichols: Sure, the question is were you able to get the federal Title X required paperwork in to the EHR without much difficulty?

Mari Dominguez: We were, but we were fortunate enough, we pursued (NextGen) through a mentoring relationship with Planned Parenthood of Utah, who is also using that software. And that is one advantage to partnering like that, they had template set up and have to meet the same Title X requirements that we were so, you know that was a big plus for us to be mentored by an organization that you know, we weren't starting from ground zero, having to build on all those Title X guidelines in requirement that you need to meet in your clinical documentation and care.

So that was huge.

Lori Nichols: Great, thank you. So I don't see any other questions in the chat queue, are there any other questions on the phone line?

Operator: No other questions at this time.

Lori Nichols: OK, let's see here. We did just get a question that came in, is (NextGen) set up with the paper work? Mari, that one's for you.

Mari Dominguez: I'm not sure, I'm understanding the question.

Lori Nichols: Let's see here. It's the Title X required paperwork and the question is, is (NextGen) set up with that paperwork or and by paperwork, I'm not sure, if they mean (inaudible) requirements.

Mari Dominguez: You can pull up for requirements out of (NextGen) and (NextGen) is very agencies can build their own templates from (NextGen) and there are some pluses and minuses to it. So and a lot of these software is little deep quite pre-packaged, which is easier probably from the standpoint of set up and if they meet your needs as a Title X agency, that's just simpler. (NextGen) you can build your templates for visits, you can build your template to have the field that you need to report on (inaudible).

But the template building process is more complicated. In those well two I should have added, one thing I would look at when you're looking at the software is how difficult or easy is it to change what you're seeing? So if you want to change the way, a visit looks or you want to add a question or field or take them away, how difficult is that, can someone on your staff do it, do you have to get a trainer from the software company?

And the other question, to keep in mind is what are the maintenance fees for the software's and my help would be overtime the cost, for these software's would come down, it is extremely expensive. We have found that, we've saved on support staff needs because what we are not doing now, to track and produce paper chart.

Some of that cost savings is going onto paying the maintenance for the software, which are you know also called licensing fees, so basically these companies, make ongoing income by having you pay fees to the company and you get access to new versions of the software and support, so those are the important things, to figure when you're making a financial plan.

Lori Nichols: Great, thank you so much Mari. I have one more question for you and it came from somebody named (Stephanie) and it's did you grow your IT department to help support your EHR?

Mari Dominguez: We did, actually what we ended up doing. We have always contracted for IT support because we are relatively small clinic, but we went from having a very sort of part-time like as needed IT support person who provides that function to a lot of other entities in our (town) to contracting with a bigger IT support on group. So they're constantly, they're remotely on all of our computers.

They're handling our storage of data and our backup of data. So it is a much bigger profile that we had prior to any HR system, and we definitely had to figure that cost in to our plan.

Lori Nichols: Great, thank you. Let me just make sure there is no other questions out there. I think we've answered all the questions that are currently in the queue. If you do think of another question, like I said after we disconnect today. Please feel free to send your questions or your comments to Caitlin and again, thank you for participation and for your interest and good luck.

Operator: This concludes today's' conference call, you any now disconnect.

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