EHR Readiness Tool Kit

PRACTITIONER FOCUS GROUP
(MTs, Managers, Supervisors, QA Coordinators)
Official Transcript
May 28, 2009

MODERATOR: Question #1: Please describe the impact of the EHR to you department or facility.

Response: Our organization was an early adopter of the EHR, using imaging for storage since 1987. We consider ourselves 83% electronic with many downstream systems sending source data back to our legal record, which is electronic. The organization is working to develop more robust clinical documentation practices such as integrated progress notes and multidisciplinary documentation pathways. We have recently lost 50% of our volume of discharge summaries to self-created documents in the clinical system. There are other similar projects underway. In spite of this, our transcription area is witnessing record-level volumes because of expansion in other services.

We are utilizing service outsourcing to handle additional workload. We have been reducing internal staff through attrition, electing instead of filling new positions, to outsource more.

Response: MT employees have been impacted in a positive way in that we now have the capability to search for transcribed documents by the same dictator when "stuck" on a word, phrase, or whatever, in order to see how other MTs have transcribed that same or similar report. We never were able to do this with "paper" records.

Response: The EMR has made the patient record available for all MT's to review and research dictation questions, issues, discrepancies etc. It has drastically reduced the number of dictations that are put in Concurrent Review on a daily basis. For studies that have face sheets, onsite and offsite can now review the face sheets and input that data directly to the dictation, thus saving another CR process. Charts were previously not readily available to the department and thus documents would be held in CR until the chart was found, information reviewed, and then completed. Now the chart is available to onsite as well as offsite staff. This means that turn-around times are less than 24 hours with studies and letters are 24 hours.

Response: It ensures accuracy in documentation of vitals, labs, and study data that normally would not be available without having to request a chart for review. Facility-wise, it has improved accuracy of patient care immensely. No longer do we have to wait until a chart is available from one department to another, and/or track down who had it last, etc, because all departments can access that record without having physical custody of that chart. Job descriptions have changed, medical records has become a quiet department with less of an active role in the charting process. There is more responsibility in the nursing department with regard to chart maintenance, updating and signing of documents/studies. The improvements in the facility are just so numerous. It has definitely changed how people perform their jobs

MODERATOR: **Question #2**: What has been the impact on workloads and staffing levels?

Response: We have evolved a Master Medical Transcriptionist into an Applications Coordinator who is primarily responsible for handling multiple corrections, testing and problem solving the multiple interfaces various EHRs in our facility. The position has proved to be invaluable, combining the knowledge of an MT with that of a chart analyst and technical advisor.

Response: I understand that we have been able to cut back on "file clerks." This has not impacted my job as an MT.

Response: As supervisor, it has drastically reduced my workload with regard to Concurrent Review (CR). Everyone is able to review the chart directly and resolve questions and/or concerns that would normally have been put in CR. I do not have to leave my desk to run to Medical Records and/or throughout the facility to locate a chart. As far as the MT's, as they are paid production it has slowed them down somewhat as they now have to research more on their own. We have not seen any drop in dictation so staffing levels remain the same. Facility overall, medical records has had the largest staff reduction and will have more as the scanning process winds down. The charting responsibility has switched to nursing and nursing staff.

Response: It was not as big an impact on them as it was on the other staff in the department.

Response: Impact to our department has been major. Hospital medical records were secondary to clinic medical records (which were electronic) and there was hybrid paper/electronic hospital medical record. Resistance from providers is still fierce.

Response: Workload has increased, staffing is static. Electronic signature is a blessing and a curse. Providers sign anything put in front of them (even electronically) and then want to edit/correct/change reports after they have been signed. In addition, because of the familiarity with the electronic clinic record, many providers refuse to accept EHR as repository for hospital reports.

MODERATOR: #3. Please describe any other roles that your staff has assumed with the implementation of an EHR. If you could, now think of specific roles. We did mention a couple in the last question, such as the scanning of documents, and someone mentioned the archiving, using expertise in archiving, and any other specific roles that your staff utilized with the implementation of the EHR. I'll open it up to anyone.

Response: The MT is responsible for ensuring that the patient is correctly identified and for choosing the correct account number (which is related solely to the date of service and facility, when known); this has become an intricate and important role for the MT, which is also now part of the QA review.

Response: None at this time.

Response: I wanted to agree, because we experienced a lot of the same kinds of issues, even though we've been scanning since 1987. Our Chart Analysts analyze everything on a computer screen now, and one of the things that we struggle with is helping the employees understand how the multiple systems interface so that the records flow to downstream systems and vice-versa. (Even while I am having this meeting, there was a discussion going on outside my door about the various codes in the database with

our provider-write index.) Also, helping the employees understand all of those pieces is something that we struggle to do all the time. As far as workloads and staffing levels, our staffing has also been flat, and it is only now that we are going through budgeting issues that we are struggling to find out how to do more with less. As far as roles that we've assumed, we have 3 levels of job classifications for our transcriptionists. We took 1 of our Master level transcriptionists and created a position that we call an "Applications Coordinator," who is an expert transcriptionist, who is credentialed, and actually works in between transcription and chart completion to problem-solve all the issues that was mentioned. Things such as reports getting signed and needing corrections and monitoring the reports that don't upload or need some kind of resolution (because we got a wrong attending physician), so the attending physician refuses to sign. She has expert transcription knowledge, and also expert computer skills so that she can help problem-solve those 2 issues. I felt that that was a growth/new role for a medical transcriptionist to take.

Response: Interface development is complex, takes longer than expected and is generally complicated. We have 5 interfaces out of our transcription application at this point in time including a bi-directional interface with our hospital EMR.

MODERATOR: That was like a "Lead Transcriptionist" or an "Account Manager?"

Response: Right. I think that is a good job title also. I think in the informatics field (if you look at health informatics) you will find a lot of the nurses are going into informatics. There is kind of a level that transcriptionists can fit because of their computer skills, and their medical terminology skills, so it is one of these positions that is still evolving.

MODERATOR: Okay, does anyone else want to add something about the roles assumed by the staff that differ from what we discussed so far?

Response: Another thing that we did is that we took our transcription coordinators who used to be responsible only for report dissemination, distribution, and handling phone calls, and we moved them into medical records in analyst positions. It gave us more coverage for transcription services, but it also diversified the roles and it was another avenue to try to educate them about the electronic interfaces and the importance of knowing that the transcribed report was going to be a part of something electronic downstream. It is not really pertaining so much to transcription, but it was another rollout from the EHR.

MODERATOR: Okay, thank you. I do want to give anybody else a chance for that particular question if you have other roles that your staff may have assumed with the implementation of the EHR.

Response: We have experienced the same thing, where what used to be our Medical Records Clerk, those people now assume the role of Chart Analysis, and as someone said earlier, we have taken the clerks and changed their roles to do prepping, scanning, and indexing. We also have them doing chart analysis. That has become a really big role now with implementation of the EHR. We have seen our staffing decrease in that area, but on the other side, our transcription staff has increased, just because with the implementation of the EHR, we were able to pick up other areas of the hospital that used to have their own transcriptionists. After we went live with the record and because employees were also fulfilling other roles, like secretarial work. We were then able to assume their transcription work. So that

has been a plus on our side. Prior to the implementation of the EHR, the secretary and transcription clerk, who pulled the reports off and filed them away or took them to the floors as needed. That person also became a transcriptionist. So, we have seen roles change in different areas of our department.

MODERATOR: Okay. Thank you. We can move on unless someone else has something else to add, I do not want to cut anyone short.

Response: I can share the role that our QA staff has currently taken on with the advent of the EHR if we have a moment. As we are implementing our EHR, of which we are in the middle of doing, the doctors do edit in the EHR as they are getting ready to electronically sign their documents, and the risk managers here were very concerned about how that was going to be monitored. So, our QA staff actually worked the queue so that any document that is edited results in their error-queue, it is an editing queue. They review it to ensure that what the doctors have edited is appropriate, that it makes sense within the content of the document. Many times they can accidently load something in the wrong way or remove something that they did not mean to. Then QA is monitoring every document that is edited and electronically signed before it is pushed over as an electronically signed document into the EHR. This is the new role that our QA staff has assumed along with their other duties. This is again driven by risk management.

Response: May I ask a question—How are you stopping them from uploading into your EHR, if you are finding the doctor's report?

Response: I don't know the technical explanation for how that is not happening, but it is held in that queue until it is released by our QA area.

Response: So, it goes into a queue?

Response: Yes. Any document that is edited is based on the code added, a configuration.

Response: So it won't upload as a signed document unless it is reviewed?

Response: No, not unless it is reviewed.

Response: hat is one of the biggest problems that we have, is finding the signed documents. We also have residents who can sign the document also before the provider does, so they can make changes in the documents. They sign and the staff doctor signs too.

Response: We are actually working that out. I just got out of a meeting a couple weeks ago where we had that whole discussion. We implemented it first in our community hospitals, so we have the same issue as you talked about where the residents can first edit and then move it on to the attending for the co-sign.

Response: What happens in our system is, if the resident signs first, then it's okay. It is still open for the staff. It the staff signs it first, then it is closed to the resident because it then is a legal document. A lot of times the residents don't have time to review the documents. They are a little more diligent than the staff doctors are—in looking at stuff. So often times the staff doctors will come in and sign stuff, and

then we have to do corrected reports because we cannot change the signed documents. I am going to see if we can do that. See if we can dedicate.

Response: They know how to tag it in some way so that it says that it has to go that queue. Okay?

MODERATOR: Thank you. You were telling me about your doctors and your facility and how that you were creating a method so that when things needed to be changed, or not allowing documents to be changed.

Response: Yes. We just did not give everyone access to create or change templates. So we limited access to that feature.

MODERATOR: Okay, so if a doctor wanted to change a template, that would centralize changing of your templates.

Response: Because we are a physician group, we wanted to ensure that we don't have people going out there and arbitrarily creating documents or templates that did not necessarily meet the compliance standards, and we also wanted to keep that process standardized, so we formed a forms committee. It consists of physicians, as well as some other clinical staff, so that when there was a suggestion made or recommendation, it would come to that forum and a decision would be made.

MODERATOR #4. Is your facility using speech recognition within your EHR? That is a yes or no question, but if you could also add the impact of that or the pros and cons or experiences, etc. I will open that up to anyone as well.

Response: Yes.

Response: Yes, but it is an older version and not very accurate.

Response: My physicians chose not to. They just felt that it was very challenging and depending on whatever dialect or accent you have, they didn't want to be bothered with it.

Response: We have back-end speech recognition in place, and have recently implemented some front-end speech recognition. We do have both in place.

Response: Today's MTs need to think like a business, understand that they are competing for work against a variety of other documentation methodologies. We need to prove our value-add in the equation. We use webinar technology that allows us to demo various EHRs and the impact, look and feel of the documentation in them.

Response: Outsource company utilizes speech recognition for hospital/clinic reports.

MODERATOR: Do you want to talk about whether speech recognition has made any difference or has a bearing on things? Is it helpful to your EHR or detrimental to your EHR, etc. Any comments?

Response: With the back-end speech recognition, we are still touching those, so I don't think it has critically changed the EHR other than being able to process those documents faster. The front-end speech recognition, we have only currently done with document types that were not being transcribed by us before. Those are some additional pieces that are getting into the record that were not there before. That is, of course, helpful.

Moderator: Okay, then my other question to that would be—Has the EHR had any bearing on your decision to use back-end or front-end, or is that something that you would probably ventured into regardless?

Response: I think we would have ventured into it regardless. They go hand in hand, actually.

MODERATOR: Does anyone else want to answer the question about whether their facility uses speech recognition? Were there any issues between a particular EHR vendor or product and the speech recognition?

Response: As far as issues, you mean any pros and cons of using speech recognition within the EHR. Is that the question?

Response: A big issue that we are looking at, especially as we look toward going to Capitol Hill next week, is concerning interoperability within the types of technology that we are using. So the question comes when adding that extra layer of speech recognition of interoperability. It is good to know which ones play nicely together and which ones do not.

MODERATOR: We do not have to specify a particular EHR system, but if anyone has a component of the EHR that might not play nicely with speech recognition, we could certainly throw that out on the table.

Response: We are speech recognized back-end, and are also using a growing number of front-end speech use. But in answer to the question, I don't think we've had any difficulties with interoperability. One of the things I think of is more data. We tend to save the voice files perpetually. There was some discussion at one point whether or not we would actually save the voice files into the EHR at some point, and we have not gotten there yet. I would think that there would be a lot of debate about that from a risk perspective or even from a storage perspective. Who wants to listen to a 15 minute psychiatric report, but those discussions do come up, and interoperability is all about data and funneling it into the downstream systems and it is going to get crazy before it gets better.

MODERATOR: Question #5 (What has been your experience with interfacing between your transcription platform and the EHR?) Does anyone want to tackle that? Has anyone been involved in the experience of interfacing that is normally left to the IT department in the hospital, etc?

Response: A good one, there are always a few bumps along the road, but for the most part the interface has worked well.

Response: My experience was in the upload of documents from Dictaphone to the EHR. Setting up the parameters so that the documents loaded to the correct tabs within the HER. There were also

characters that were not loading correctly and coming across with E errors. Making sure that documents load to the correct tab within the chart. Watching for any errors in this process.

Response: Working with IS Department and vendor to ensure that worktype templates, signatures, ADT information flows into EHR correctly and that signature deficiencies are assigned to correct providers (dual signatures – residents/staff

Response: That is normally left to the IT department to manage, whether it is an outside service or an internal department.

Response: I can speak from an MTSO perspective in that amongst 21 oncology centers last summer, that one facility acquired. All of them were using different systems and brought them all onto 1 EHR system, called "OncoEMR," and we actually had to write code in order to get the information to upload into that "OncoEMR" system. It was not the EHR vendor that said, "here is our product"; we had to create our own solution to make it work, which is kind of ironic.

MODERATOR: Question #6: How did you prepare your staff to work with an EHR? We talked about the staff and different staffing levels, but if you could talk about how you prepared your staff, such as physicians as well as the other departments and your MTs, etc. Anyone can tackle that question as well.

Response: It was a gradual process for us, with in-services and classes when necessary.

Response: The IT department and the EHR company provided general usage instructions to the entire practice prior to the go-live date. During the first few weeks of the go-live, I reviewed what the potential issues the MT's could encounter and how best to juggle 2 screens while doing certain work types. All Mt's were trained on a one-to-one basis, as well as, handouts that I developed for reference.

Response: I supervise one employee who was impacted by conversion to EHR at main campus hospital. Developed table with different scenarios as issues arose. Worked with her one-on-one.

Response: I could talk about it briefly if you would like me to. Specifically, our QA training staff, as we worked with the EHR and medical records department to implement, we made sure that they were involved with some of the decisions that were made and how that queue was going to work. They look of the queue. We worked with them to train them on the platform. We made sure that not only did they understand the piece that they were responsible for, but also the bigger picture. As we looked at our transcriptionists, I had been bringing a lot of material back from various meetings and groups about the electronic health record, talking to them about the HiTech Act, reviewing newspaper articles. We used the bulletin board, talked in staff meetings, and just made sure that they understood what the transition into those new roles were. Some of the things were undefined. We made sure that they had as much information as possible about what was/is happening nationally, regionally, and locally with the electronic health records. Sometimes people will come to us, like managers, or supervisors, and say, "What do I need to do?" We talked about what their goals were and what their future may look like, about what their current educational background and experience is and we made suggestions. Some of the staff we have recommended to them that they brush up their technology skills when they are weak in those areas. They may need to work on their bachelor degree if they only have an associate's, and learn healthcare IT. It really depends on keeping them well informed and working with those individuals

who want to seek further education and experience. For us it is not "one-size-fits-all," but more just getting information out to them for us has been key.

MODERATOR: Okay. Would anyone like to piggyback on that? Thank you for that, that is a lot of information!

Response: I have a question again. How much involvement from the EHR vendor, like how much support and education do they provide when you are implementing or adding new modules, and such? What is the expectation there?

Response: It is about how much you are willing to pay for training and the modules that determine what you are getting. Sometimes we just train the trainer, and then they give the internal training. I really think that what people do depends on the vendor and the organization. What was your experience from the MTSO side?

Response: The EHR vendor trained the client, and then the client attempted to train us. We ended up finding out that we knew more than the client. What I am hearing from you is that you had to do a lot of your own research in providing information to your staff.

Response: When I say we had to provide training to our staff—yes, we worked with the vendor to provide training to the QA trainers who were working that queue for the edited documents, but I was speaking in generalities about keeping our staff informed about the electronic health record in general. That was more us than the vendor. That was more general than high level, more about the electronic health record and what is happening in this country and about what some of the impact of the HiTech Act and about what it means to us as transcriptionists. Really, I am talking about general education. For the specifics with the QA training staff that are doing that particular function within the EHR, it was a combination of the vendor and us and the HIM department preparing them as the HIM department was preparing their staff in the electronic health record. There was involvement from the vendor. The other piece was just generally keeping our staff well informed about what is happening with the big picture, not just what is happening here with the Health Alliance and with that particular vendor, but across the country.

MODERATOR: Okay, thank you. Does that answer your question?

Response: Yes, it does. I am getting a sense from reading and listening that there is a variety of different products out there, but the amount of support that is going to come with it as it comes down to the practitioners. Obviously, you two are working for well-established organizations, where we are working from home.

Response: Yes, it is a broader spectrum of implementation.

MODERATOR: Can anyone share with us if their hospitals or facilities had certain training methods for their EHR system implementation. How much of that training trickled over to your transcription department or outsourced transcription, vendors, etc? Does anyone have any insight on that?

Response: I'd be glad to speak to that. We had the vendor teaching/training the trainers, but there was also a lot of preparation ahead of time that surveyed the skills of the existing staff to make sure that if there were pieces staff needed to update. For instance on the transcription end in particular, a couple of them had to look at brushing up on their MS Word skills, others were urged to become more familiar with technology terminology. Within each job category within the hospital there were specific questionnaires for them to make sure that they had the skills going into the training, and making sure that they were up-to-date in those before the training ever began. There was training specifically for the physicians, and for the nurses, and for the lab, etc. It seemed to work pretty well. The vendor was on hand. They had at least 5 people on the first full week that we went live with the product, and then just 1 or 2 tech people the week after that. It was a situation of sink or swim! There were some issues that had not been settled when they left the site, and those were some of the things that are the same with any system. Staff ends up finding the bugs as they go through it. There was extensive training and there was extensive preparation ahead of time, which I thought really made a big difference.

MODERATOR: Thank you. Anyone else want to add to that?

Response: I think a couple of the things I would comment on is, that we very much believe in keeping the transcriptionists and anyone else who is going to be impacted "in-the-know" so that when their roles changed and when all of the training was impending, it was not such a shock to them, and they had the time to get used to it. We have always designated "super users," and that has always been successful for us. They are somebody who would go and be trained, whether it was by the vendor or whatnot ahead of time. Then that person becomes the point-person for everyone else to lean on afterwards. That is another highly recommended way to go.

Response: I just wanted to say that we had a lot of extensive training prior to implementation, and of course, afterwards we also had to train the trainer. It is an ongoing training right now as things change or with new implementation for the transcriptionists, and as we hire new transcriptionists. We actually offer as part of their training program, training in the EHR . We go in and show them how to look for anything they need to do to perform their job. It is very important to make sure that the training continues.

MODERATOR: Okay. With that being said, I know you mentioned that when you hire, you go through this training. Can you talk to us about what you are looking for when you are hiring—are you looking for certain qualities or experience for the staff that might make you say "that is a good fit for what is going on with our EHR system."

Response: Definitely those who have computer knowledge, and even with our staff that was here prior to the implementation, are given classes in the operating system for MS Word just to get to know the computer better. We do look for employees who have either the HIM background or HIT OR HIA, or definitely computer-savvy knowledge of different systems. It is very important.

MODERATOR: Okay. Thank you. I wanted to read a comment so we did not forget about her. She said that "It seems there is a wide variety of support that is being offered by EHR vendors, especially considering large facilities/organizations versus the individual healthcare providers… especially as the country moves forward with implementation of the EHR at all levels of healthcare." Does anyone want to speak to that—in your facilities does it seem that you get huge vendor support, as far as what your

facility needs, or are there any strategies that you had to employ to get what you need from EHR vendors, clients, or staff?

Response: I think she was trying to say that the EHR vendors are being supportive with large facilities with training, or implementation or whatever is needed. Do you find that to be the case in your facilities?

Response: I will try to answer that question—I've been trying to process it while people comment. We are probably not that unique in that we deal with a lot of different vendors, and it is almost like you name it, and we have it. We have Meditech and McKesson and Impac and we are an Eclipsys customer, and e-Scription is in the middle of it, and we have Nuance for front-end and I am even thinking of my wife, who works in a dental practice, that they have an ABELDent program that is out of Canada that they utilize. There is no solid answer with all of those applications concerning which vendor is more supportive or less supportive. You really get what you put in. With some vendors that we have, we have taken all of the control because we had to. We had to try things and learn things, and I know other vendors that have real solid training programs, and I know some vendors that have a thousand-page user manual, but people cannot find the answer they need. It all seems to boil down to, well the folks in this room having this conversation today. We are the leaders and we end up figuring it out and making it work. She does that in her MTSO by writing the code, and she is doing it in her area by training the trainer. You get what you put into it. Back to my wife and her ABELDent program—when she covers for the manager, she always comes back and says, "there are so many shortcuts that we are not using because they have not been trained," or "they do not know, or they do not want to risk it." So, as leaders we are trying to educate our people to be as smart and as intelligent as they can, and then go off and take that risk to press a button or try something and get it to work.

Response: I have been listening to this all and am amazed at the amount of ideas and thoughts that are coming across from the folks that are participating. I have made a list with bullet points from everything from clinical improvement to training and transition, and I think there is really a lot of material that we could actually turn around into a document that you wanted for a deliverable. Even if people volunteered to fill in under sections and titles, we come up with some kind of narrative that has an outline. It might be a good next step.

MODERATOR: I agree. Tiffany is celebrating on this in the chat window. Thank you. I do agree. It is a lot of information. That is one of the reasons that we conducted the focus groups because we know that people are doing so many different things in the industry and that we could bring together and sponsor a focus group that would be helpful to go forward. Once people are educated about these things, they feel empowered and are more apt to want to tackle it. That brings us to any additional comments. If there are any other things that you think are valuable that we have not covered you think might be beneficial to this project, please comment, any comments in general as well.

Response: I'd like to make a comment. I think that all of the people that have participated in this discussion today have been very informative and I am just really thankful that everyone has been here today!

MODERATOR: I agree. Does anyone have any comments or questions or additional information they would like to share?

Response: I was just going to ask if Tiffany could get a user-list of attendees because while I know some in the room, I don't know everybody or what organization that they are from, and it would be helpful just to know the group representation at some point.

MODERATOR: That would be great, and I think Tiffany can do that. One thought process I had was also trying to maybe find some information from practitioners, hospitals, or MTSOs where transcription has been eliminated so that we could also have some information from that perspective. A situation where someone has successfully implemented an EHR and eliminated transcription. I have not heard a lot about that, so I wanted to dig and seek it out to find the balance of information. What do you all feel about that?

Response: I think that is a great idea. I know that it has happened, but I do not have (other than the transcriptionists that have lost their jobs) had a real solid contact there, so I cannot really talk about it.

MODERATOR: We might put together a call for some of that information to include in the deliverable as well because it would be interesting to find out whether that has happened, and whether it is focused on a certain group or specialty, hospital, etc. We are now going to wrap things up as long as there are no more additional comments.

I thank everyone for attending.