TCCHCC WIRELESS MEDICARE RN PROJECT: BPI CASE STUDY

Project Description
TCCHCC resident assessment department has a team of four RNs whose sole responsibility is to complete multi-page MDS health status forms for patients who receive Medicare. Upon completion, these time-sensitive forms are electronically transmitted to the state of New York to determine reimbursement benefits for TCCHCC. Currently, these are done on paper at each unit, and then keyed in by data entry clerks in the resident assessment department. In order to reduce errors on these MDS forms, minimize lost MDSes, and decrease rejections from the state, these RNs will be given wireless laptops to enable them to complete the MDSes in the system at the point of interaction on the units.

As-Is Process
Harriett Anderson, RN, takes a blank MDS to a unit. At the nurses station, she consults the patient's chart and clinicians to fill out the MDS. Once the MDS is complete, she returns it to the resident assessment department for the director's review. After approval, the MDS is given to a data entry clerk, who keys it in, and transmits it to the state.

Problems with the current methodology
1. If Harriett makes mistake on the MDS, and doesn't have additional blanks, she needs to return to resident assessment to get more, since the MDS needs to be completed in black ink, and white out is not allowed. In some cases, this could cause up to a 30 minute delay, depending on which unit she's working on.
2. The chart may be missing, or in use by another department or clinician. Or, the chart may be incomplete. In both cases, Harriett cannot complete the MDS, and will need to return to the unit at a later date, thus delaying the MDS' completion. This requires her to keep track of incomplete MDSes, which could lead to misplaced or lost forms.
3. The director receives a myriad of MDSes for review from each of the four RNs every day. Delays are inevitable, and MDSes are sometimes misplaced by the director, or lost in the paper-shuffle.
4. Once the director is finished reviewing an MDS, and it has corrections, it is then sent back to the RN to be fixed. The director then reviews it one more time and approves it. This multi-stepped process involving hard copies is ripe with the potential for lost MDSes.
5. Approved MDSes are given to the data entry clerk, who keys in hundreds of these multi-paged forms daily. The clerk sometimes misreads information and keys in the wrong data. If this happens, and the MDS is rejected by the state, the MDS needs to be fixed and resubmitted to the state, which causes major delays.

To-Be Process
In order to minimize the problems with the current process, each Medicare RN will be given a new Dell Inspiron laptop with wireless capability. Strict adherence to HIPAA rules will ensure that sensitive patient health information is securely stored on the AS/400. Harriett will take her laptop to a unit and input the data directly into the clinical software. If there is information (or a chart) missing, she can save her work and return to it later. Once Harriett is done with her MDS, she emails the director, informing her that the MDS is ready for review. The director can then pull up the MDS in the system and go through it. If there are corrections to be made, the director emails Harriett, who makes the appropriate changes. A final review by the

director is initiated by an email from Harriett. Upon completion, the director emails the data entry clerk who then batches the completed MDSes together and transmits them to the state.

Resistance
The four RNs were generally satisfied with the new program. They liked having their own laptops, which gave them a greater sense of ownership over their work. Having spent many years entering the clinical data on paper, they were hesitant to use the computers, as they were concerned that it would take longer to complete each MDS. There was a steep learning curve for each of them, but after multiple sessions of one-to-one training, they began to see the benefits of the new process. They also became more adept at entering the data. Additionally, the two data entry clerks were concerned that they were going to lose their jobs, as work was being taken away from them. The were reassured that this was not the case, as there were many non-Medicare MDSes that sill needed to be keyed in, and electronic batches of MDSes still needed to be sent to the state.

Post-Mortem
This project had the backing of senior management. A new wireless network was installed throughout the facility to make this project possible. Once the four RNs got the hang of the new clinical system, we were able to see a reduction in lost MDS forms, and a decrease in the rejections from the state. However, there were some unforeseen challenges that we needed to address:

1. One of the RNs was not able to carry the laptop due to physical limitations. We therefore purchased a rolling laptop case for her.
2. The resident assessment director was printing out copies of the MDSes submitted to her by the RNs in order to review them. Since minimizing the use of paper was one of the goals of the project, we explained to her the need to review the forms on the computer instead.
3. There were several wireless dead-zones in the facility, which needed to be identified and mapped so that the RNs knew where they could work. We tested the wireless network throughout the facility and instructed them as to the best places to work.

Conclusion
Overall, senior management viewed the project as a success. Long-term care has been extremely slow to adopt new technologies to help with the burden of paperwork, and our facility was seen as a shining example to our sister hospitals. In the future, an electronic work-order system will hopefully be implemented in conjunction with this new process.