Seamless transition from paper to AHS EHR

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Embrace the new world of healthcare
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- 5 yr. AHS and Galen Certified EEHR Consultant
- **Project Manager**
- **Upgrades (v10 to V11)**
- **Implementations & Conversions**
- **System Administration Training**
- **Workflow Assessments and Optimization**
- EEHR Basic Functionality Training

Build and content expert with nearly 18 years of IT Healthcare experience and 5 years of hands on experience with the Allscripts EEHR application.

I have a solid and effective background in EEHR support, training and product build, as well as an extraordinary number of successful upgrades and implementations.

My specialty is “training the trainer” and is the person responsible for the development and implementation of the Galen Healthcare “Workflow Workshop”.

I know the healthcare community well and is highly effective and comfortable in both the boardroom and support room with strong communications skills, listening capabilities, patience and encouragement.
Your phone has been automatically muted. Please use the Q&A panel to ask questions during the presentation!
Making the tough, but right decisions

The difference between a great transition and a poor one, begins with the decisions you and your organization makes prior to transition itself.

Sometimes the toughest thing and the right thing are the same thing!
Transitioning from paper to Electronic Health Records

- Performing your due diligence prior to Go Live!
- Ensure your practice and patient charts are adequately prepared for providers.
- Explanation and demonstration of why the abstraction process is paramount to your success
- Prerequisites to Going Live
- Best practices to optimizing the adoption of EHR
Performing your due diligence prior to Go Live!

Have your v11 notes been defined and put in place for your specialties

Have your V11 Workflows been evaluated and confirmed as viable for each role

Have you decided on the MU objectives to be used in your organization and specialties and are they measurable?

Will your organization require additional resources for training and go live support

Have you determined the date for your go-live
Ensure your practice and patient charts are adequately prepared for providers

Given your workflows, consider where to place your hardware

Desktop scanner for the front desk to scan in Insurance Cards and Licenses

Printers to print out Clinical Summaries, Rx’s, both controlled and uncontrolled and printer trays to accommodate both

Is your PM system interfacing with the EHR to populate patient demographic information and scheduling

Have past results been scanned into the Chart and are they easily accessible

Have the patient pharmacies been updated in the chart
Why the abstraction process is paramount to your success

Abstraction is the process of recognizing and focusing on important characteristics of a situation or object and leaving/filtering out the un-wanted characteristics of that situation or object. For example: A doctor sees (abstracts) the *person* as patient. The doctor is interested in name, height, weight, age, blood group, previous or existing diseases etc… of a person.
The who and why of patient data abstraction

An MA, Nurse, LPN... not a non-clinician

There are laws in place that tell us who can enter patient data, even historical data, into a patient's chart without further verification from a provider and who cannot.

There are three Preferences within the AHS EHR specifically for the purpose forcing a provider to verify all historical data or allowing the provider’s staff to do it.

- Enable Rx-Orders Verification
- Enable Problem Verification
- Enable Allergy Verification

*If a non-clinical staff member is entering the history of Problems, Meds or Allergies the Preferences have to be set to yes, which means that all of this data will go into the chart as “unverified” and the provider will have to verify every bit of it on Go Live.*

*If a clinician enters the data it goes in verified and the provider can simply review*
Decision – who abstracts patient data?

Clinical staff makes the most sense

Why?
– They can read the providers handwriting
– They know the providers practice habits
– They can enter historical data as “verified”
– They know medical terminology, signs and symbols

Where do they start?
– With regularly scheduled patients
– With patients scheduled for the week of go-live

How far back do they go? 3 months, 6 months, a year?
On day one, what is the most critical data to have abstracted to most effectively treat the patient?

- Current meds
- Allergies
- Active problems
- Immunizations
- Vital Signs
- Social History
- Past Medical History
- Past Surgical
Go Live preparation Checklist

- Adoption and preparation meetings have been attended by staff to ensure all parties are on the same page – including organization IT staff
- Patient Data has been entered into the patient chart and is easily accessible
- Notes and note forms for specialties have been approved and placed in the Live environment
- Provider schedules have been reduced
- Scanners are in place for front desk and medical records (if necessary) and have been tested
- User logins have all been validated
- All PC’s, Laptops Tablets and printers have been tested as well as any wireless access points
- All staff and physicians have been thoroughly trained
Adoption and Commitment

Who will your Physician Champions be?
Who will lead the Physician Champions?
Physician Champion

A Physician Champion is an expert that provides education, champions a cause or product, or gives support to staff around the diffusion and implementation of clinical practice guidelines and protocols.

In all cases, the Physician Champion is perceived as credible and having the ability to persuade others. Oftentimes the Physician Champion is able to influence other physicians to adopt or implement a new or revised process or guideline for the improvement of care quality or to become a physician champion themselves within their own practice groups.
Backwards Thinking

The Perfect Conversion

Part one
Front Desk - What did we learn

Scan Insurance card and License
Update Demographics
Update Pharmacies
Process Demographic MU alerts
Flag patients location and status

Requirements
PM, EHR, Scan Module, Desktop Scanners, Training

Dictionaries
Site Location, Encounter Status
Clinician - What did we learn

✅ Can be done pre-conversion

Open Note (Note is an enormous undertaking) (Time and resources)
Take Vital Signs
Enter Chief Complaint
Review/ Record Current Meds (who abstracts and verifies)
Review/ Record Immunizations
Review/ Record Problem History
Review/ Record Allergy History
Review/ Record Social History
Review/ Record Past Medical History
Review/ Record Past Surgical History
Address MU alerts
Flag patients location and status

Requirements
EHR, V11 Notes, History recorded as verified, Training
Physician - What did we learn

Open Note
Review Vitals and Chief Complaint
Review Current Meds  (verify if abstracted by non-clinician)
Review Immunizations (verify if abstracted by non-clinician)
Review Problem History (verify if abstracted by non-clinician)
Review Allergy History (verify if abstracted by non-clinician)
Review Social History (verify if abstracted by non-clinician)
Review Past Medical History (verify if abstracted by non-clinician)
Review Record Past Surgical History (verify if abstracted by non-clinician)
Review Of Systems
Physical Exam
Review Past Results  (Scanned into ChartViewer until Interface installed)
Assessment, Plan, Discussion/Summary
Flag patients location and status

Requirements
EHR, V11 Notes, Physician, Discrete Patient Data entered by Clinician, Training