

IMPLEMENTING COMPULINK'S ELECTRONIC HEALTH RECORDS (EHR)



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Two very important points to remember:

- **Implementing EHR is a process, not an event.**
- **There is no one "Best Way" for implementing EHR.**

Even though there's no one "Best Way", there are certainly some practices & processes that have worked well for others. Our job is to share these with you, detail the positive and the negative aspects of each, help you decide what will work best for your practice, and detail the tasks that EVERY practice must complete in order to have a successful implementation.

Software-Specific Implementation Considerations

Whether you're already using Compulink's EHR module or you're going to start using EHR for the first time with v9, there are some important tasks that MUST be performed by every practice. The exact steps can be very different for each practice, so it's important for these tasks to be fully discussed by the Implementation Team.

1. Review Setup:

It is essential that all stake-holders spend some time going through all parts of the EHR module. You should:

- Review the various exam layouts,
- Review all of the drop-down list (libraries),
- Review the "EHR Notes" (that may be entered in Optical Recommendations, Test Findings, etc.), and
- Review any other information generated by the EHR (printouts, exam summaries, letters, etc.).

2. Modify Setup:

Once you've taken time to completely review all aspects of the default setup, the Implementation Team should agree on all changes that need to be made. You should consider differences by different doctors, and differences that might be required by different specialties. The following are frequently modified to meet a practice's unique requirements:

- Changes to the exam layouts - adding / removing tabs, modifying the layout of fields, etc.)
- Changes to the drop-down lists (libraries) – add items, remove items, modify items
- Changes to the EHR Notes – add items, remove items, modify items.
- Changes to the Assessment & Plan pick lists.
- Changes to the Complaints and HPI lists.
- Changes to EHR-related output – exam summaries, letters, etc.
- **NOTE** – Customization of these items by Compulink’s Trainers is NOT included with the purchase of Compulink’s EHR module.

3. Practice Sessions:

Finally, all clinical staff must spend time practicing with real patient data. A good method is to meet in the afternoons and use paper charts generated during the day as examples for your practice sessions. The practice sessions accomplish several things:

- You’re able to identify problems areas or areas of confusion, and then implement necessary changes.
- You’re able to become proficient with the use of the EHR module without the added pressure of having a patient sitting in front of you in the exam chair.
- You’re getting real medical record info loaded into the EHR records.
- Your speed and accuracy will improve rapidly.

Some practices do these practice sessions for a couple of weeks and some might do it for as long as 30 – 60 days. When you’re all comfortable with the process and you’ve worked out the majority of the changes that are necessary to make the EHR module fit your own unique needs, you’ll be ready to “go live”.

One more point about practice sessions. You should go through your complete patient flow using a simulated patient and real data. This step is going beyond simply entering the data into the EHR, and taking it to the point of practicing through the entire patient visit. You should also simulate different kinds of visits, especially if your practice has a number of specialists – go through a glaucoma visit, go through a retina evaluation, go through a new patient general visit, go through a CL visit, etc.

Required Client Activities

ALL USERS:

(These activities are for everyone going live - those going live with EHR for the first time with v9 and those already live with EHR and upgrading to v9.)

1. Read this EHR Implementation Guide in its entirety.
2. View all of the EHR Tutorials.
3. View all of the EHR Webex classes:
 - a. Electronic Health Records Overview I
 - b. Electronic Health Records Overview II
 - c. Electronic Health Records Tables
 - d. Screen Builder I
 - e. Screen Builder II
 - f. Screen Builder III
 - g. Introduction to Print Designer
 - h. Smart Events (coming soon)

CURRENT EHR USERS:

(These activities are only for those already live with EHR and upgrading to v9.)

1. Review information on Forwarding (clients who are already using EHR and moving from v8.1 to v9).
2. If you have created your own custom fields and custom layouts, run a test conversion so you can see how these layouts will work in v9.
3. If you have created your own custom fields and you want to print from them, you might have to create print layouts using the new Print Designer. This is a relatively simple process. You can convert your 8.1 screens from the screen layout to the print layout and then copy the fields to a panel so that it doesn't need to be lined up. Of course, you can modify that layout if you wish. The Print Designer will allow you to generate Adobe PDF files.
4. If you want to continue using the History command to display summarized information from your old records, you might have to modify your History files slightly due to changes in the way files are named in v9. This is particularly true for some of the date fields.
5. Mapping Default Fields –
 - a. Compulink offers a mapping service which will move your legacy data from the default fields into the new sub-table fields. This will allow you to view your legacy data in the new sub-table grids.

- b. There is no charge for mapping the DEFAULT fields from previous versions to the appropriate DEFAULT 9.0 fields.
- c. Additionally, 5 custom fields may be mapped at no charge. Mapping of more than 5 custom fields will incur a charge.
- d. Please contact Compulink's Customer Care department to discuss the details of the Field Mapping Service and to request a document which covers this topic in detail.

General Implementation Considerations

1. Create an Implementation Team that manages the process and creates a specific implementation plan and specific time lines, and nominate a Project Manager (usually a clinician and NOT a low-level employee):

- Clearly define your goals for what you want the EHR to do and make decisions based on these goals.
- Consists of the Project Mgr & members of other office teams
- Project Mgr – needs specific time to coordinate pre-implementation decisions, meet regularly, etc.
- Consider visiting other offices w/ Compulink to discuss implementation.
- Meet weekly to refine implementation plan and discuss needs.
- Team also needs to allow the staff and physicians to voice their concerns and fears about the implementation process so that they can be taken into consideration.
- Create a positive environment and get everyone excited about the implementation.
- Develop a Timeline that everyone can access, so that everyone knows where you are in the process and everyone knows what they're supposed to be doing. (A sample Timeline is attached at the end of this guide.)

2. Analyze your work flow and your current processes, and re-design / modify those processes accordingly:

- Analyze every function of every job to understand how tasks are currently being accomplished.
- Look for opportunities for improved efficiency, designing new work flows that could be accomplished with the tools available in the EHMR and developing a transition plan.
- **Clearly document all of your processes.** This makes it easier to train people on what they're supposed to do, and it makes it easier to hold people accountable.

Identification of Workflows (these may vary among practices):

1. **Billing and accounts receivable:** This includes creating and managing patient accounts, inputting demographic information, billing for services, processing accounts receivable and posting payments.
2. **Scheduling:** This includes making appointments for patient visits, confirming appointments and acknowledging patients as they arrive.
3. **In-house messaging:** Some method must exist for passing messages between staff and physicians. This includes phone messages from patients, phone or other messages about patients, e-mails with patients or in-house e-mails.

4. **Documentation of patient interactions:** This includes documenting summary information (e.g., past medical history and review of systems), disease-management flowsheets and the like. It also includes generating de novo prescriptions for patients as they are seen.
5. **Processing refill requests:** This involves responding to requests for refills that arrive by multiple methods - phone messages, faxes, e-mails, etc. It also involves reviewing the clinical records for these patients to render a clinical decision.
6. **Reviewing and acting on the results of diagnostic tests and lab results:** This involves reviewing the data generated by your diagnostic testing equipment and lab results, documenting that the results have been reviewed, and acting on the results as appropriate. It may also involve reviewing charts, signing reports and placing them in the chart, and communicating medical advice to the patient.
7. **Managing external correspondence about patients:** This involves reading, signing and filing the tens or even hundreds of documents that arrive every day by mail and fax, including X-ray reports, correspondence from consultants, old records, disability forms requested by patients, hospital records, emergency room reports, etc.
8. **Charging out optical jobs (contact lenses and / or glasses):** You need to think about the changes to your existing processes that EHR will allow. Data can now be transferred directly to the Spec Rx and Contact Lens Rx screens, so you need to have processes in place for handling this and for how orders will be placed.

3. Are any facility modifications required?

- Have a good understanding of what the patient and staff flow would be with the EHR system functioning in the existing space. This is essential for planning where to put the new EHR equipment.
- Computers will need to be in the location or convenient in the office where staff would need to look up or enter data into the record. You will also need to consider if you need printers where staff members will be handing printed materials to patients
- Where does the hardware need to be placed? Once this is determined, will additional electrical and network wiring need to be handled. Will other areas need to be created? Exam room considerations – how is the computer going to be located to still allow eye contact with the patient.

4. Hardware selection and installation:

- There are many choices throughout the office: hardwired desktop computers, mobile notebooks, touch screens or tablet devices at the workstations. Look and test the latest models. State the Advantages and Disadvantages with each.
- Will you use scribes? What is the best equipment for them to use?

- Setup a small, off-site test installation of the server, workstation, printer and scanner to test the use of all of the products together. You can also use this to view and practice on the software
- Install all hardware 2 months prior for staff to get used to computer use & technology, especially if not utilizing computers.

5. IT Concerns:

- **Redundancy:** You need to have redundancy in your server – hard drives, power supplies, etc.
- **Security:** Update log in rights for staff for access to records
- **Equipment Interfaces:** How do you want data transferred from equipment? Are you utilizing interfaces? There are several types of interfaces of equipment available for assistance paperless entry. Or do you want to continue with Data entry?
- **Backup System:** have multiple methods of backup and recovery & test several times before going live.

6. What are you going to do with your old paper charts?

The answer to this question depends a lot on the amount of time you have available prior to implementation, your budget, your staffing, and the needs of clinicians, but the answer usually involves one of two methods or some combination of the two: **scanning charts or pre-loading pertinent data**. Before either process is started, all old records and records of deceased patients or patients which have moved should be purged.

Most people keep seven years' worth of paper charts onsite, and there is seldom a justification for scanning or pre-loading all of your old charts. There's little likelihood all patients in those seven years worth of charts will visit your office, so focus on the most recent, "active charts". Over the years, you'll be able to destroy a number of old charts and gradually reduce your paper charts to nothing.

However you chose to handle this important function, be sure to carefully document the process you create. This makes it easier for everyone to know exactly who should be doing what and when they should do it.

- Scanning** - Determine what will be scanned in and when it will be scanned. Will you scan as patients come in or will you do this prior? Is it only recent data? If scanning all patient data, then how recent? Is it only patients within the past 2 years? Do you want to buy more expensive multi-sheet scanners or single-sheet scanners?

(Be sure to view the sample scanning protocol on Page 12.)

Drawbacks to scanning:

1. Scanning can be a VERY time-consuming function.
2. Scanned documents are merely images which must be viewed and can't be entered into database fields.
3. Scanned data can't be merged into consult letters, followup letters, and exam summaries.

Specific Actions to Consider:

1. Which scanner(s) to use?
 2. Scanner ROI – A more expensive, high-speed scanner could save you 100's of hours.
 3. When will the scanning take place?
 4. Scanner speed and resolution
 5. More scanned data means more data, which means longer time to backup. This could affect your choice of backup.
- b. Preloading Data** – With this method, you would determine the most important information that you have in paper charts and pre-load this information into your EHR. The benefit is that the data is available for forwarding into the first complete exam posted into EHR, the data can be printed in merge documents, the data can be manipulated like other data, and the data can be displayed in summary printouts. Some of the most common things preloaded are: PFSH, IOP's., Med's, Refractions, Problem List, Vitals, Alerts, Testing History, etc.

Drawbacks to pre-loading:

1. Pre-loading data will take some time.
2. You'll have to decide what is most important to your clinicians.

Specific Actions to Consider:

1. Create "Pre-load Data" Template.
2. Determine what information from previous exams needs to be pre-loaded.
3. Add Pre-load flags to Patient Demographic screen and / or paper chart ("Scanned", "Electronic", "Chart off site")

NOTE: No matter which method (or combination) you choose, the doctors must review the data that has been scanned or pre-loaded and determine if everything need is available to them. If not, you need a protocol for scanning / pre-loading any additional information.

7. What will you do with paper data that comes into the office?

As one of the implementation tasks, analyze the various categories of test results, hospital paperwork and other information that flows into the office each day and

decide how to manage them. If this data has not been electronically merged into the EHR, then you will need to scan in these documents. Determine the best types of scanners to use that meet your volume, that provide the resolution necessary, and that fit your budget. You'll need to create specific processes for receiving this data and for getting the documents scanned in to the EHR.

8. Exam Posting and Coding: Who is posting and coding the exam visits? How does that have to do with patient flow? Is your clinical staff trained to do this?

9. Training / "Going Live":

Pre-live Training:

- a. Initial basic skills assessment performed in house – determine the areas in which the staff has strengths/weaknesses.
- b. Basic skills training performed in house by staff – for those needing basic training, get them up to speed.
- c. Most successful implementation occurs when the practice allows plenty of time to use the program before going live, as we stated at the beginning. Doctors and staff should practice familiarizing themselves with the program from their home PCs or before or after office hours on the office computers through Compulink's Webex and Tutorial training. It is also suggested that the office have several computers available so that staff can practice, using actual patient charts. Be sure to review and compare notes on individual issues that arise during your practice sessions.
- d. Application-specific training performed by Compulink trainer – this will be determined by Compulink who will take into consideration the size, location and other staff training issues. "Power Users" should be determined and given opportunities to train intensely prior to going live. If there are any major changes in work-flow, then either documentation or presentation of this should be produced prior to training.

Live Day(s):

- a. Those that are present should be your Compulink trainer, the in-house trainer or 'power user' and project manager.
- b. Schedule lightly for the first week or so to allow for a few more minutes between each patient. Some practices choose to use EHR at first only for new patient visits or some other sub-set of their full patient load, but this isn't the best method. If you've gone through all the considerations in this document, planned accordingly, practiced appropriately, and lightened your schedule, you should have few problems entering all patients' visits into the EHR right from the start.
- c. Be sure you have a contingency plan for times when problems occur with the EHR or something else that you haven't planned for. Try to avoid falling back on paper charts if you can, but, if you must, enter data on paper and then complete the EHR at the end of the day.

- d. Create and displaying signage in the office to explain the use of a new computer system is sometimes helpful.
- e. Keep everyone positive, stay focused, and all of your planning and hard work will pay off.

10. Ongoing meeting of the implementation team, clinicians and key staff:

As we said at the beginning, implementing EHR is a process, not an event. Therefore, your implementation team will need to meet for many months after going live, possibly less frequently, but these meeting should continue.

11. Sample Workflow Procedures / Protocols:

SEE ADDENDUM A

12. Sample EHR Implementation Timeline:

SEE ADDENDUM B

13. Frequently Asked Questions:

SEE ADDENDUM C

ADDENDUM A

Sample Workflow Procedures / Protocols

SCANNING PROCEDURES

Charts will be pulled and placed in the area below the "To Be Filed" charts, and sorted by the day the patient is to be seen.

The front desk will then take the stack of charts over to computer to scan. It is EXTREMELY important to have the correct patient with the scanned documents. Verify name and date of birth on each chart with the information on the patient screen.

Rule of Thumb for Scanning:

- Last 3 exams regardless of date
- All special testing (MRI's, X-rays, etc)
- All correspondence with other doctors/clinics
- Progress notes for past two years
- Glaucoma tracking sheets
- Scan prior HIPAA Acknowledgements and Financial Obligation policy sheets
- Arrival Sheets for 2007,2006,2005
- School Exams
- CL Documents
- Informed Consents
- Release of records from other offices

Once scanning of chart is complete:

- On the bottom right of each page that is scanned, stamp "SCANNED" and the date and your initials.
- Use the pull-down menu in the software to tag as "Electronic Chart".
- Stamp "SCANNED" on the outside of the chart.
- The charts will be available to the doctor who is performing the exam, and the doctor is to confirm that everything necessary has been scanned into the software. If something else needs to be scanned, the chart should be taken back to the front desk.
- Place in the file bin by day of week of appointment. (Mon-Sat) All charts are put in a box at check out and quality checked. At this time we check the "Off Site" box on the patient's demographic screen. Take charts and file them alphabetically in the back in boxes that say off site. **They can go to storage 1 week after they have been seen.**
- Scanned charts are to be stored separately from unscanned charts in storage. Make sure that they are labeled clearly.

ADDENDUM B

Sample EHR Implementation Timeline

Internal EHR Timeline

| <u>Date</u> | <u>Who's Involved</u> | <u>Item</u> | <u>Time Needed</u> | <u>COMPLETED</u> |
|-------------|-----------------------|--|--------------------|------------------|
| March 10 | | Formation of Implementation Committee (suggested members: Billing, Techs, Doctors, Scribes, Checkin / Checkout) | | |
| March 12 | | Implementation Committee views EHR Webexes / Tutorials | | |
| March 13 | | Managers meeting to discuss patient flow & distribution of implementation duties: *Review current workflow / protocols and identify changes needed *Document workflow changes *Test / Practice workflow changes *Who will review EHR drop-down lists (tables), EHR Notes, Printed output, Screen Layouts *Determine Access rights required for EHR / Sign-off rights *Discuss Hardware options *Billing / Posting procedures *Assign Webex / Tutorial by duties *Confirm Equipment Interfaces desired *Assign a Committee Leader (Point Person for communication with Compulink) | | |
| March 15 | | Finalize modifications of Appointment Schedules to reduce patient volume for Live Days. | | |
| March 17 | | Staff registers for EHR Webex / Tutorials | 90 minutes | |
| March 18 | | Implementation Committee & I.T. staff finalize hardware selection *Exam rooms @ Main Loc installed and tested by Friday 4-6-2007 *Exam rooms @ Satellite Loc installed and tested by 4/7/07 *Printer, Scanners & other peripherals installed and tested Friday 4-8-2007 | | |
| March 20 | | Scanning Charts / Data Pre-load Protocol Completed Revisions to EHR Notes, Assessment & Plan Tables completed | | |
| March 21 | | Staff registers for second viewing of EHR Webex | 90 min. | |

| | |
|---------------|--|
| March 26 | EHR Committee Meeting – finalize changes to current processes & procedures |
| March 28 | EHR Committee Meeting - review progress / current areas of concern, screen update |
| April 5 | EHR Committee Meeting: <ul style="list-style-type: none"> *Schedule internal training on new procedures for Chief Complaint / HPI (techs) *Review of patient flow *Status of all table build outs *Review new clinical procedures *Scanning procedure defined |
| April 9 | ALL TABLE MODIFICATIONS MUST BE COMPLETED BEFORE THIS DAY BY 12:00 NOON |
| April 10 | Equipment Interfaces Installed and Tested / Access on exam room computers / Train on usage. <ul style="list-style-type: none"> *Scenarios for training – Use real patient charts as examples, that give a broad example. <p>EHR Practice – Including techs and doctors, using sample patient scenarios.</p> <p>(NOTE: This process could take much longer. You should all the time necessary to ensure that your doctors and clinical staff are proficient with the software before you go live.)</p> |
| April 9 - 11 | |
| April 13 | Pre-enter data from paper charts for next week's patients |
| April 14 | Scan in information from paper charts for next week's patients |
| April 16 | LIVE WITH EHR!!! |
| April 16 - 20 | At the end of each day, review process / software changes needed. |
| April 20 | Live Week Review of EHR Implementation / Define Actions Needed |
| April 23 | Back to normal appt schedule for templates. |

ADDENDUM C

Resources List / Web Sites

NOTE: Compulink is not recommending any of the companies listed below, but is listing them for your reference and consideration only. Please refer to Compulink's official support site for information on other tested, researched and recommended hardware - <http://compulink-support.com/faq.htm#peripherals>.

Instrument Stands:

<http://www.rushop.com/index.cfm?fuseaction=shopping.display&subcatid=4&pageid=82&parentid=2&parentpage=0>

<http://www.ergotron.com>

Motion Computing Tablet PC's:

<http://www.motioncomputing.com>

<http://shop.lenovo.com>

High-speed Scanners:

<http://www.ambir.com/page.asp?issue=185>

Canon Model #DR5010C:

<http://www.usa.canon.com/opd/controller?act=OPDSupportDetailAct&fcategoryid=2341&modelid=11293>

ADDENDUM D

Frequently Asked Questions (FAQ's)

1. Where do I start?
 - See #1 in General Implementation Considerations section.
2. What about my old paper charts?
 - See #6 in General Implementation Considerations section.
3. How will I know which patient is in which room?
 - By using the Patient Tracking function,
 - By using "temporary charts" that merely contain summary patient information that is shredded after the visits
4. What should I use to enter my patient information?
 - See #4 in General Implementation Considerations section.
5. If I want changes to exam screens or new screens created who would do that?
 - This can be done by Compulink (for a fee) or by the user.
6. How will my doctors and staff learn to use the electronic medical record?
 - Compulink will train them.
7. How do I know if a test has been performed and is ready for review?
 - Compulink's software includes "Workflow Management" functions that will alert the physician that a test has been performed and is ready for review.
8. Who will modify/ create letters that I want to send regarding exams?
 - Compulink uses Microsoft Word and provides some sample letters. Almost all practices will want to modify those letters to meet their own unique needs.
9. What processes or protocols do we need to review in our practice?
 - Patient Flow / Arriving the patient
 - Scanning / Pre-loading old exam data
 - Ordering, performing, interpreting tests
 - HPI / Chief Complaint entry
 - Exam Coding & Charge Posting
 - Flow of optical information from EHR to Rx
 - Handling refills and patient calls
10. When do records lock for editing?
 - AutoLock - You can pre-determine the number of days you want the record available for editing.
 - The software first checks for any provider sign off fields completed. If one is found then record is locked. If login ID of user matches ID found in a populated sign-off field then user has ability to edit locked record.
 - If no provider sign off is found but date exceeds autolock period then record is locked, however any user with provider sign-off may edit record.
11. How do I sign my records?
 - Compulink includes an electronic sign-off function.

12. When will my equipment interfaces be installed?
 - Generally, they are installed a week or two prior to onsite training, so that they can be tested.
13. How will this impact my patient flow thru the office?
 - See #2 in General Implementation Considerations section.
 - Your flow will be impacted in many ways. How you checkin patients, how you document refill requests and phone calls, how charges are posted to the ledger, how exam letters are printed, etc.
 - All of these items are things that your implementation committee should consider and test. Then, after careful consideration and testing, the new processes should be documented.
14. If we want to post charges from our exam rooms what will I need to consider?
 - You will no longer need routing slips.
 - You will now be able to post office visits and procedures at one time.
 - Do you doctors and / or techs have coding knowledge to apply modifiers, or will you need to have your insurance billing staff simply review charges for correct coding / modifiers. (This is something that most offices should do in all cases.)
15. Should I scan the old patient records?
 - See #6 in General Implementation Considerations section.
16. Do I need to save a paper copy of the exam and keep paper charts?
 - Generally, No.
 - You only need to save those old items that were not entered or scanned into the new system and that are legally necessary to save.
17. Should we pre-enter patient data?
 - See #6 in General Implementation Considerations section.
18. What should I consider in relation to "going live"?
 - See #9 in General Implementation Considerations section.
19. Should I continue / start using a scribe?
 - If you already use a scribe, the transition to EHR is much easier because the doctor only has to change the way old exam data is reviewed.
 - If you don't already use a scribe, then you want to consider the doctors' comfort / ability to enter data. Most practitioners that don't use scribes, do not start using scribes simply because they are moving to EHR. In fact, it generally happens the other way.