



## **RESOURCE AND PATIENT MANAGEMENT SYSTEM**

# **EHR Onsite Go Live Schedule**

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Office of Information Technology  
Albuquerque, New Mexico

# RESOURCE PATIENT MANAGEMENT SYSTEM ELECTRONIC HEALTH RECORD CLINICAL APPLICATION COORDINATOR & IMPLEMENTATION TEAM ONSITE “RPMS-EHR GO-LIVE”

## 1.0 Background

The RPMS Electronic Health Record (RPMS-EHR) is a new suite of software applications designed to move most clinical transactions from paper-based to an electronic environment. The EHR uses upgrades of existing RPMS applications and clinical data, but provides a graphical user interface (GUI) that facilitates access to and direct entry of this data by clinical users. The two most significant clinical enhancements provided by the EHR are the direct entry of orders (pharmacy, laboratory, radiology, nursing, etc.) by providers, and the on-line documentation of clinical encounter notes. In addition, the EHR will make clinical decision support tools available to providers at the point of care, and will make the medical record immediately accessible to all authorized users.

Implementation of an electronic medical record at any health care organization is a complex and lengthy process, requiring preparation and changes in essentially all areas of a medical facility. Rolling out an electronic record system at any facility will require a considerable training effort at the time of implementation, as well as an ongoing program of training and support.

## 2.0 Purpose

The Clinical Application Coordinator (CAC) and members of the RPMS-EHR implementation team provide ongoing operational support for certain RPMS packages that comprise and/or interface with the Electronic Health Record. This onsite technical consultation will assist CACs, Pharmacists, Laboratory and Radiology Technicians, Clinical Champions, Medical Record Administrators, Data Entry Operators, Business Office Professionals, Site Managers and other facility staff with the initial “live” use of the Electronic Health Record software.

The EHR Deployment Team will be onsite to discuss and troubleshoot any issues that the facility has encountered with the EHR, as well as mentor facility staff when they first use the EHR with patients.

It is strongly suggested that (a) one consultant will provide mentoring to the primary care providers while (b) the other consultant(s) will follow the orders and information through to Pharmacy, Radiology, Lab, Medical Records, PCC Data Entry/Coding, and Business Office.

### **3.0 Tentative Schedule, Goals, and Objectives**

#### **3.1 Day One**

**Time:** 8:30 AM – 12:00 PM  
1:00 PM – 5:00 PM

- Welcome and Introductions
- Meeting with EHR Implementation Team
  - Goals, Objectives, Expectations
  - Which elements of the EHR the facility has been utilizing
  - Problems/issues that have arisen
  - Training plan for facility staff
  - Plans for Go-Live
  - Policies and procedures
  - Baseline measures and metrics
- Mentor/assist facility staff with use of EHR, to include:
  - Physicians
  - Nurses
  - Dentists/Dental Hygienists
  - Pharmacists
  - Laboratory technicians
  - Radiology technicians
  - Medical Records
  - Coding
  - Billing

#### **3.2 Day Two – Day Four**

**Time:** 8:30 AM – 12:00 PM  
1:00 PM – 5:00 PM

- Mentor/assist facility staff with use of EHR, to include:
  - Physicians
  - Nurses
  - Dentists/Dental Hygienists
  - Pharmacists
  - Laboratory technicians
  - Radiology technicians
  - Medical Records
  - PCC Data Entry/Coding
  - Business Office

### **3.3 EHR Clinical Providers**

- Review Electronic Health Record Tabs
- Creating and Selecting a Visit
- Enter Triage Data
- Document Exams and Refusals
- Document Health Factors and Patient Education
- Document Personal Health
- Document Immunizations and Skin Tests
- Document Purpose of Visit
- Update the Problem List
- Document Services and Procedures
- Review Lab and Radiology Results
- Review the Medications Tab (Chronic Meds, Process Medications, Order New Medications, Change Views)
- Utilize the Orders Tab (Quick Orders, Medications, Allergies/ADR)
- Write a Progress Note
- Use a TIU Template for Documentation
- Utilize Notifications
- Establish Personal Preferences and Views
- Print from the Electronic Health Record
- Utilize Pediatric Growth Charts
- Sign all notes and orders
- Review Minimal Documentation Requirements
- Review Use of “Clinicians Guide”
- Review “EHR How To” in “Clinicians Guide”

### **3.4 Pharmacy**

- Completing Pharmacy Orders
- Review of Electronic Health Record Tabs
- Creating or Selecting a Visit
- Documentation of Medication Education (Counseling) on the Same Day Medications were Processed.
- Documentation of Medication Education (Counseling) on a Day Different than Processed.
- Document Purpose of Visit
- Review Lab and Radiology Results
- Write a Progress Note
- Use a TIU Template for Documentation
- Utilize Notifications
- Establish Personal Preferences and Views
- Print from the Electronic Health Record
- Sign all notes and orders
- Review Minimal Documentation Requirements

- Review Use of Clinicians Guide
- Review “EHR How To” in “Clinicians Guide”

### **3.5 Lab and Radiology**

- Accession Orders
- Review of Electronic Health Record Tabs
- Creating or Selecting a Visit
- Review Electronic Health Record Tabs
- Electronic Health Record Documentation for a Patient who has Lab Performed on a Day Different than Ordered.
- Creating and Selecting a Visit
- Document Purpose of Visit
- Review Lab and Radiology Results
- Write a Progress Note
- Use a TIU Template for Documentation
- Utilize Notifications
- Establish Personal Preferences and Views
- Print from the Electronic Health Record
- Sign all notes and orders
- Review Minimal Documentation Requirements
- Review Use of Clinicians Guide
- Review “EHR How To” in “Clinicians Guide”

### **3.6 HIM, PCC Data Entry, Coding, and Business Office**

- Validating Information in the Electronic Health Record
- Review of Electronic Health Record Tabs
- Broadcast and Communication
- Correcting Electronic Health Record Information (Roll & Scroll vs. GUI)
- Use of PCC Error Reports (Pages in Error Report, Uncoded Diagnoses)
- How to Fix Uncoded Diagnosis
- Use of “Coding Template”
- How to addend the “Coding Note” to the Providers Note
- How to request a co-signature for the addended note if required by Compliance Plan.
- How to send a notification
- Utilization of Coding Queue (PCC Data Entry Patch 8)
- Correcting Documents Entered in Error
- TIU Reports
- Review Use of Clinicians Guide
- Review “EHR How To” in “Clinicians Guide”