A Publication of the Quillen EHR Team

February 2013

Volume 3, Issue 2

Quillen Quick Notes

Upgrading Allscripts to Version 11.4.1

We are currently in the early stages of preparing to upgrade the Electronic Health Record (EHR) system. As we plan ahead for the next stage of Meaningful Use (MU) and ICD-10 compliance, our EHR must be capable of handling new requirements.

The upgrade could occur as early as Spring 2013, and we will be providing more details as they become available.

In the meantime, your EHR Support Team will be very busy in preparation. The system build will take several weeks, and everything will have to be tested and re-tested, before a rollout can be considered.

From a high-level point of view, the upgrade to Allscripts Enterprise 11.4.1 has three major areas of change:

1. Orders Adoption
2. Meaningful Use Stage 2 Certified Solution, and
3. Allscripts Patient Portal Adoption.

Allscripts' goal is to improve the usability and adoption in these key areas:

- **Documents as Results/ Attachments to Orders**

⇒Documents in the Chart Viewer can be set as a result for an order or as an attachment to an order.

⇒A document can be viewed, printed, and sent to Allscripts Patient Portal along with the order.

- **Note**

⇒Ability to spell check from within the Note Authoring Workspace.

⇒New "End of Encounter Medication" section allowing you to see Current Medications at the end of the encounter.

⇒New section available to show Future Appointments.

- **Demographics**

⇒Ability to document more than one race for a patient

- **Problem Reconciliation**

⇒Ability to document that problem list reconciliation has been performed, similar to medication reconciliation.

⇒Ability to invoke duplicate checking from the problem list.

- **Rx/ePrescribing**

⇒A redesign of the Rx Renewal Request Dialog—allowing providers to view the patient chart while reviewing the request.

- **Patient Portal**

⇒Stage Two MU requires providers to provide their patients access to their health information electronically, as well as the capability to receive messages from their patients electronically. As we move into Stage 2, we want to ensure our Allscripts Patient Portal meets all of the requirements.

We will keep everyone updated as we move forward. Our goal is to make this a smooth transition!

Inside this issue:

EHR Challenge

January Challenge Winner

Beth Trinkle, a nurse at Bristol Family Medicine, was last month's challenge winner. Congratulations, Beth!

February 2013 EHR Challenge

What does the "Y" under the "D" column on the Task List indicate about the task?

Task your answer to the Allscripts Help Team to participate in this month's drawing.

The winning entry will be drawn randomly from all the correctly answered submissions.

Good luck!

Visit the QETSU EHR Website

The Quillen Physicians EHR website is a tremendous resource at your fingertips.

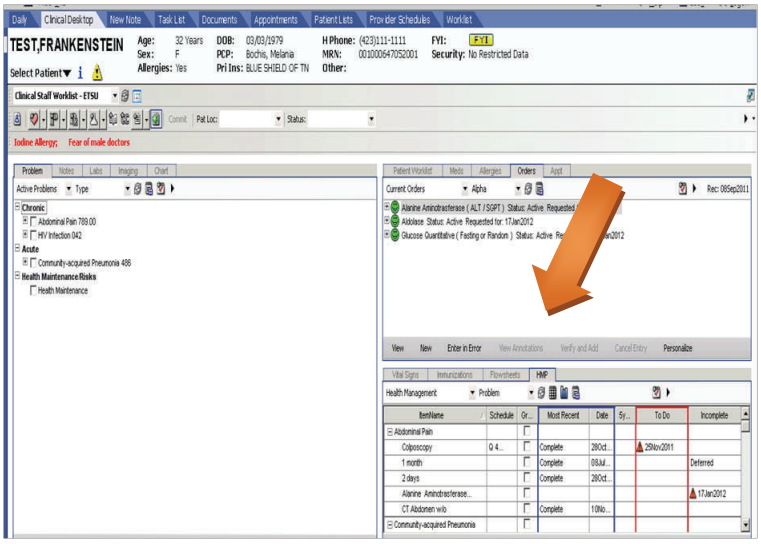
You can easily access Training Manuals, How-To Documents, Training Videos, and more.

http://quillenphysiciansehr.weebly.com/

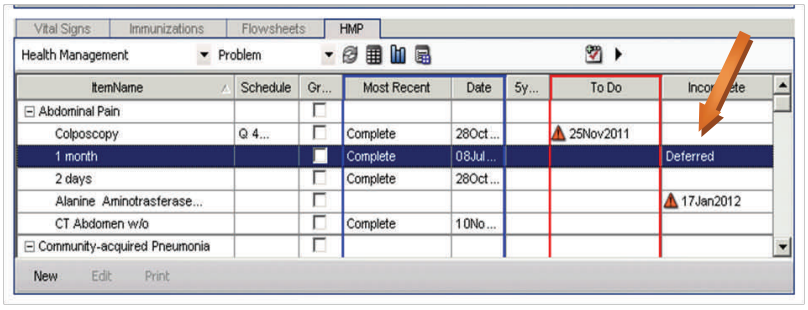
From the Developer Zone: Stopping a Deferred Item

Sometimes a deferred order must be edited. If that 's the case, you should stop the deferral before it is edited.
If you have an item in a deferred status, and you need to stop the deferral, do the following:

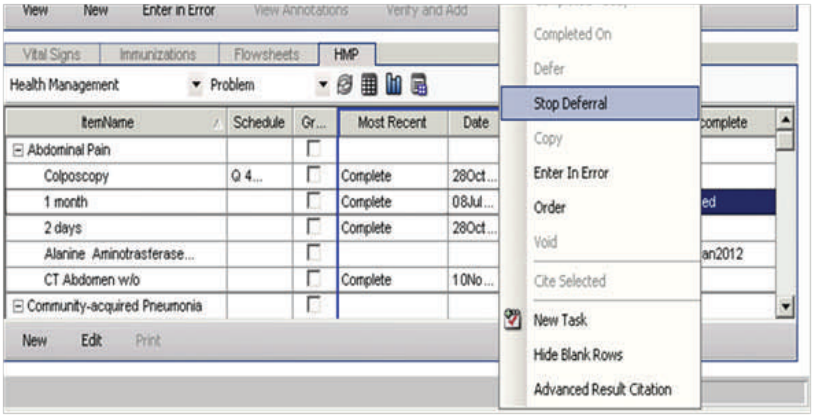
1. Navigate to the **Clinical Desktop** and the **HMP** tab in the **3rd component.**



2. **Find the item** that you deferred. In our example, we deferred an appointment.

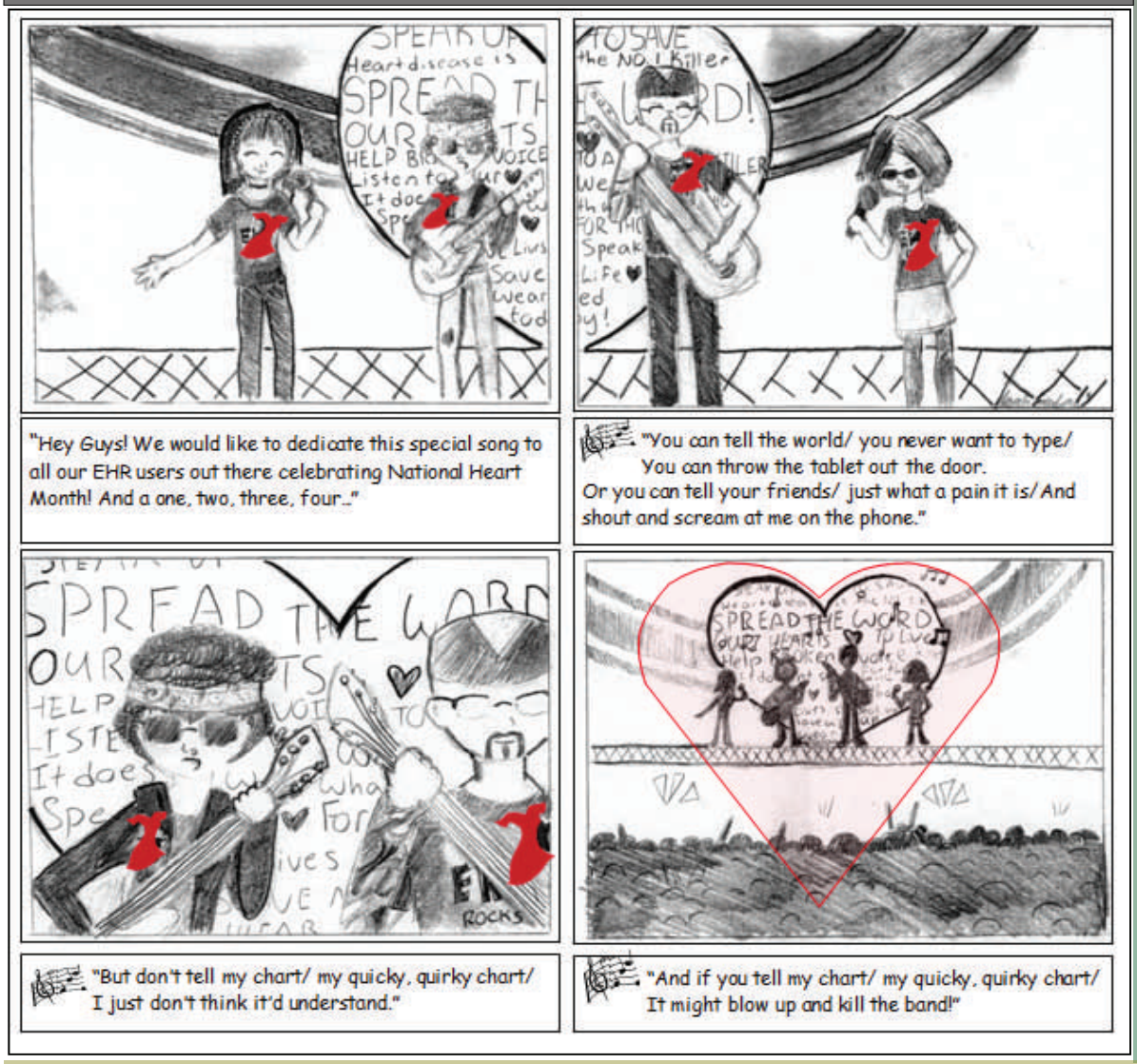


3. Right-click on **Deferred**, and choose **Stop Deferral**



EHR ROCKZ!

February 2013

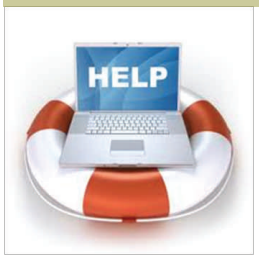


Did you know...?

As of December 2012, CMS reports that 74,003 eligible providers have been paid a total of $1,493,767,128 in the Medicaid EHR Incentive Program.

Yes, you read that correctly...over a BILLION dollars have been paid nationally to help cover the cost of EHR implementation.

EHR HELP DESK



The Help Desk is available Monday through Friday, 7:30 am until 6:00 pm.

When contacting the **Help Desk,** consider the nature of support needed. **For urgent needs** (such as inability to log in or perform your job duties), Call 282-6122 (option 1).

If your question is non urgent, select from the following:

- **Task** the **Allscripts Help Team**
- **E-mail: EHRhelp@qetsu.org**
- **Open a Help Desk Ticket** by clicking on the QITS Help Desk icon on your desktop.

After-hours support is very limited. If you should have an urgent need, send an e-mail with a return phone number to EHRhelp@qetsu.org. Should a member of the EHR Support Team be available, someone will get back in touch with you as soon as possible. Please note that messages left on voicemail after hours will not reach us until the next work day.

Are you a Meaningful User? Meaningful Medications

What makes a medication meaningful? I suppose that ANY medication that is prescribed to a patient should be meaningful, but what happens when a patient's medication list is maintained on the EHR, but the list isn't accurate? Would an incomplete or inaccurate list be meaningful to anyone?

Let's for a moment suspend the idea of a medication's "usefulness" to the patient and examine the "meaningfulness" of the medication's inclusion on the medication list. Perhaps the best way is to present a few patient scenarios:

Patient Scenario One

Patient One, "Mary Meaningful," visits a clinic because she has allergy symptoms. She currently takes an over-the-counter decongestant, as well as a few vitamins and supplements. She also takes an anti-anxiety medication that she asks not be included on her medication list. Not wanting to cause Mary any distress, the nurse records her medications in the system (absent the anxiety medication) and sends her on to see the provider. Mary doesn't mention anything about the anxiety medication to the provider because she feels embarrassed that she is taking it. The provider feels sure the medication list is accurate because it has been reconciled by the nurse and prescribes Mary an antihistamine.

Do you see the potential hazard here?

Dangerous interactions can occur when antihistamines and anti-anxiety drugs are taken together.

Patient Scenario Two

Patient Two, "Mike Meaningful," shows up for his annual Medicare visit. He reports to the nurse that he has been seeing one of the cardiologists for some heart-related issues and that he was prescribed some medications a few months ago. She pulls up his chart and doesn't see any medications on the list. When she questions Mike, he tells her that the doctor was too busy at his appointment and didn't have time to put them in the system. He just wrote them out on prescription paper.

How meaningful is the medication list now?

One provider's responsibility has now been pushed off to another provider's clinical staff, and, consequently, takes more time and is potentially less accurate than using the system the way it was designed.

Patient Scenario Three

Patient Three, "Misty Meaningful," was originally prescribed 25mg of a blood pressure medication by her primary care physician, which was ordered through the system correctly. A few weeks later, Misty's blood pressure hasn't improved so the clinic calls in a higher dosage—50mg—but doesn't record the change in the patient's chart. Misty visits her specialist, who sees the dosage is 25mg but knows she is taking 50mg, as she reported to him. He decides she needs to take 100mg, and renews the medication at the higher dose. Unfortunately, Misty has a bad reaction and files a malpractice suit. When the defense attorney reads the specialist's note, it appears that he upped her dosage by 75 mg because no one recorded the 50mg.

Where does the fault lie?

Obviously, no one could have predicted the bad reaction, but how can we rely on the accuracy of a medication list and the system's ability to accurately reflect a provider's plan when no one takes the time to document in the EHR?

I could describe many more patient scenarios in which the lack of accurate medication documentation has

(Continued on page 6)

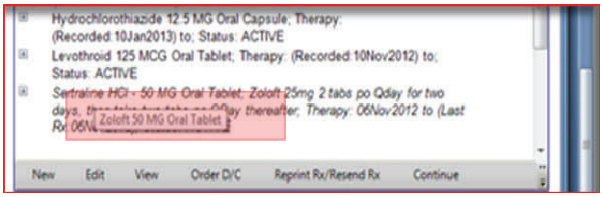
Meaningful Medications (continued)

caused problems, but I think you get the point. Even when clinics were on paper, keeping an up-to-date medication list was very important for good patient care, but now, with the transition to an electronic health record, and with multiple providers using the same chart, each user must be particularly careful to accurately document. **If we strive to make the medication list truly meaningful, the end result can only mean <u>better patient care</u>.**

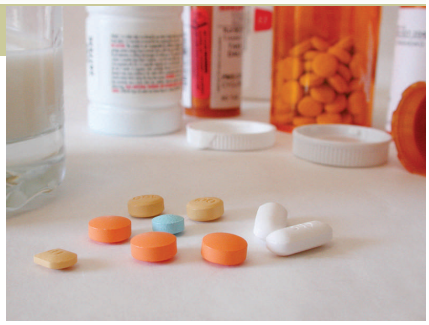
Below are some recommendations on how to ensure the medication list is up-to-date and accurate (i.e. MEANINGFUL!):

1. Make sure that clinical staff has a good understanding of generic medications and their brand names. When a nurse asks the patient about current medications, both the generic name and brand name should be considered when doing the reconciliation. Even though the patient says he is taking Ambien, the medication may be prescribed as a generic (zolpidem). If the clinical staff person doesn't know the difference (and the patient doesn't either), they may inaccurately remove the medication from the patient's medication list.

Quick Tip: Hover the curser over the generic medication's name (generics are listed in italic font) to see the brand name.



2. Medications can be put in the system two different ways: 1) Recorded by using the medication history tab, and 2) Ordered in the system through the Rx tab. Medications that are recorded in the system are completely "editable," meaning that they can be edited without the medication falling into the provider's plan. Ordered medications that are edited fall out of the Current Med list and into the Plan section of the Note. Clinical staff should **NOT** edit a medication that has been ordered in the system without talking to the provider first.

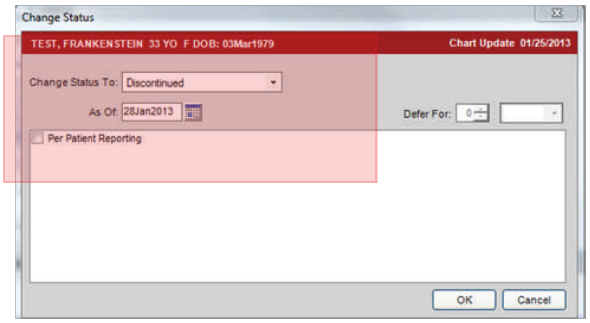


3. The medication list can be **printed** for review if the provider feels more comfortable updating the list on his own. For this workflow, the nurse prints the list and makes notes based on what the patient reports. When the provider sees the patient, she can use the list to confirm with the patient what needs to be updated. This process may not work for every clinic workflow, but it could be used temporarily as a way to educate clinical staff on the proper way to document the medication list.

4. If an ordered medication needs to be updated, consider how it should be updated so that it doesn't show up in the plan inaccurately.

- "Complete" a medication if the patient reports that they are no longer taking the medication and no refills have been ordered for the patient.
- <u>Record</u> a "Discontinue" if the patient reports that he or she is no longer taking the medication, even though the medication hasn't expired.

Quick Tip: Right click, "Edit," and then change the status to "Discontinued." Click the box "Per Patient Reporting."



Both "Complete" and "Record Discontinue" will move the medication off of the Current Medication list and onto the Past Medication list.

Note Compliance: Signing and Finalizing Notes

COMPLIANCE FOR SIGNING NOTES

Oversight Committee Recommendations

Note: Medicare requires that all office notes be signed within 48 hours of the patient's appointment. The following policy constitutes MEAC's policy for penalty of physicians who fail to comply with this requirement.

Step 1: The EHR Administrator will monitor the "Unsigned Notes" task lists. If a note remains unsigned for 7 days, the EHR Administrator will contact the office manager by email, and will copy the chairman of the department and the physician whose note(s) remain unsigned. If the individual departments would like these emails to be forwarded to someone other than the chairman and the office manager, they are to contact the Compliance Officer with an appropriate contact person(s).

Step 2: The office manager/chairman will provide counseling to the offending provider. If deemed necessary by the clinic chair/office manager, an education session will be scheduled so that an EHR team member can provide one-on-one training to the provider. The provider will be informed that they have 3 weeks to complete their unsigned notes.

Step 3: During the third week, if the notes remain unsigned, the department chair will meet with the provider and explain that if the notes have not been completed by the end of the week, their charges will be held until their notes have been signed.

Step 4: The office will be informed to hold charges for the provider's visits until their notes have been signed and the Compliance Officer has confirmed full compliance. The Compliance Officer will let the billing department know when they can begin billing the provider's charges.

For physicians on guarantee, it is recommended that Step 4 above be replaced with:

The office will be informed to block the provider's schedule until their notes have been completed. The Compliance Officer will let the office know when the provider's schedules can be unblocked.

Electronic Signature Your Name Here

Next Go-Live: Quillen ETSU Fertility and Women's Services

The next site to Go-Live on the EHR will be **Quillen ETSU Fertility and Women's Services**. Training began on January 30, and will continue through February 1, 2013.

If all goes as planned, the actual Go-Live day will be on February 4. The EHR staff will remain on site during the entire week, just as we have done with other locations.

We look forward to this Go-Live, and expect all to go well.

Stay tuned for an update next month!