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## practice management

### Part 2 of 2

# Allow time to implement EHR

Be sure to include training, take things slow, think through changes

**Editor's Note:** The first installment of this two-part guide (part one appeared in Ophthalmology Times March 15, 2010, pages 44 to 46) discussed the preparatory steps to installing an electronic health record (EHR) system, including forming an implementation team, analyzing processes, preparing for the technology demands, and customizing your software.

Now it is time to discuss the steps for actual implementation. This can be called the "go live" day. The following pearls will help the project manager and the implementation team on their journey to successful EHR integration.

By Jeffrey T. Grant

**A**lthough one of the greatest benefits of EHRs is that you no longer have to store paper records, you have to decide what to do with an entire room full of paper. The answer will depend on your time available before implementation, budget, and clinician needs, but will most likely be a combination of pre-loading pertinent data and scanning charts.

### Plan for the paper

The first step is to determine which records need to be digitized. Although most offices keep 7 years worth of paper records, it is unlikely that all of those patients will visit your office again. Many offices work with the most recent, "active" charts and then are able to destroy the old records over time. You will need to decide if you will do all of this before your EHR implementation, or as patients come in.

The next step is to decide what information

### Take-Home Message

When you are converting your practice to an electronic medical record system, make sure you allow plenty of time for proper training. Also, take it slow at first and think through all necessary process changes.

is the most important in the paper charts, and pre-load this into your EHR. Some of the most common things to be preloaded are PFSH, IOPs, Meds, Refractions, Problem List, Vitals, Alerts, and Testing History. Preloading data takes time, so it is important to determine what is really important to your clinicians beforehand.

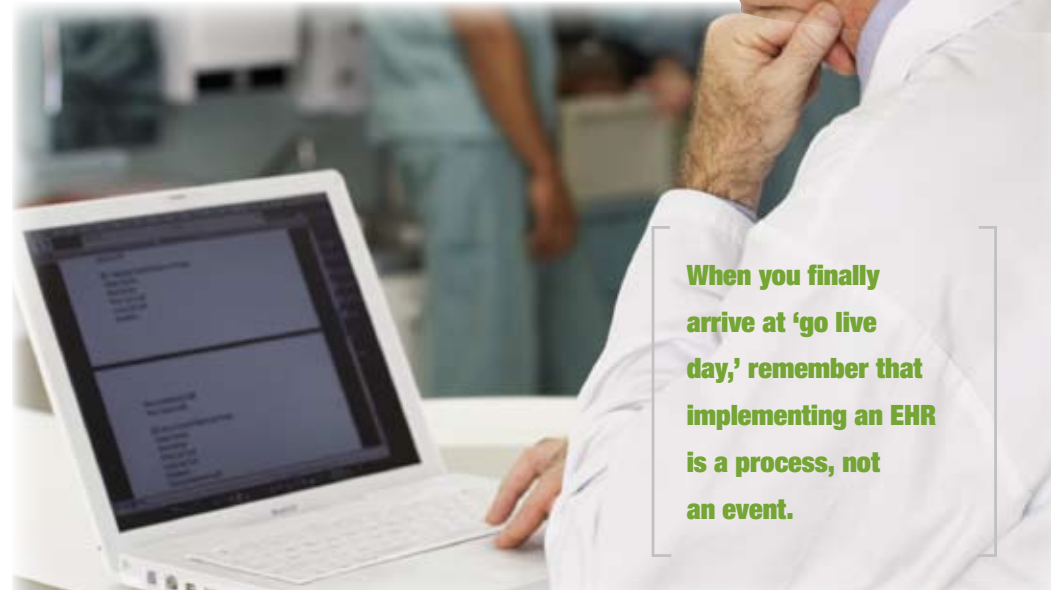
The third step is to determine which of the remaining information in the chart needs to be scanned. It is important to remember that while scanning in pertinent records is important, scanned documents are merely images to be viewed. The information is not inserted into database fields and cannot be used to merge letters or create exam

summaries.

Analyze the various categories of test results, hospital paperwork, and other information that flow into the office each day and decide how to manage them. If these data have not been electronically merged into the EHR, you will need to scan in these documents.

When you know what information you are going to scan, you can determine when scanning will be done and which scanner to use. A high-speed scanner is expensive, but could save you hundreds of staff hours.

No matter which method (or combination) you choose, the physicians must review the data



When you finally arrive at 'go live day,' remember that implementing an EHR is a process, not an event.

## Common processes to review

- Check-in
- Hand-off from check-in to clinic
- Clinical documentation
- Billing/coding/posting of charges and diagnosis
- In-office messaging
- Documentation of all patient interactions
- Generation of correspondence
- Data/patient handoff to optical or contact lens/surgery scheduling

## New processes to be created

- Scanning/loading paper charts
- Destroying/storing paper charts
- Notifying the tech staff that a patient is ready
- Confirming that charges were posted

## What to scan

- Last three exams, regardless of date
- All special testing (MRI, radiographs, etc.)
- All correspondence with other doctors/clinics
- Progress notes for past 2 years
- Glaucoma tracking sheets
- Scan prior HIPAA Acknowledgements and Financial Obligation policy sheets
- Arrival sheets for last 3 years
- School exams
- CL documents
- Informed consents
- Release of records from other offices

that have been scanned or pre-loaded and determine if everything needed is available. If not, you need a protocol for scanning/pre-loading additional information.

### Get enough training

Ask any practice that has had a bumpy transition to EHR and they will tell you that two of the biggest mistakes they made were 1) not enough training and 2) not enough time for training. Both can be avoided by determining who needs to be trained and who will do the training.

You may want to conduct an in-house assessment to determine each staff member's strengths and weaknesses, and then determine who will be posting and coding exam visits and if your clinical staff is able to do this.

For detailed application-specific training, it is well worth the investment to bring your EHR vendor in to train staff. They should take into consideration the practice size, location, and other staff training issues. "Power Users" should be identified and given opportunities to train intensely with your vendor. These users can then train the other basic users. If there are any major changes in workflow, then documentation or presentation of this should be produced prior to training.

After initial training, allow plenty of time to use the program before going live. Physicians and staff should familiarize themselves with it from their home PCs or before or after hours on the office computers using vendor-supplied online and tutorial training. You should have several computers available so that staff can practice with actual patient charts. Review and compare notes on individual issues that arise during your practice sessions.

### A process, not an event

When you finally arrive at "go live day"—when you flip the switch from paper to electronic—remember that implementing an EHR is a process, not an event. Plan that even after going live, your implementation team will continue to need to meet

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for many months.

Here are some additional recommendations to help make the transition go smoother:

- Have your vendor trainer, the in-house trainer, or "power user" and project manager present at your live day.

- Schedule lightly for the first week or so, allowing for more time between patients. Some practices choose to use EHR initially only for new patient visits or some other subset of their full patient load, but this is not necessarily the best method. If you have planned accordingly, practiced appropriately, and lightened your schedule, you should have few problems entering all patients' visits into the EHR from the start.

- Have a contingency plan for when problems occur. Try to avoid falling back on paper charts, but if you must, enter data on paper and then complete the EHR at the end of the day.

- Keep everyone positive and stay focused, and all of your planning and hard work will pay off. **OT**

## author info



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