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Moderator: Caitlin Hungate
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Caitlin Hungate: Welcome and thank you for joining us for part two of our three part electronic health record webinar series. Embarking on an EHR system from Thought to Action presented by Tom Dawson, SA Kushinka at Full Circle Projects, and Patrice Capan, Family Healthcare Incorporated. My name is Caitlin Hungate and I am from the National Training Center from Management and Systems Improvement funded by the Department of Health and Human Services Office of Population Affairs.

The National Training Center from Management and Systems Improvement is committed to assisting Title X clinics to respond to today's rapidly changing healthcare landscape. We will begin shortly with the presentation.

Please be aware that there will be the opportunity to ask questions of the presenters. You may ask questions via the phone line by pressing star one or by chatting your questions in via WebEx. Due to the large number of participants, it is unlikely that every question will be answered. If you have a question that is not addressed we encourage you to contact me, Caitlin Hungate, at the National Training Center for Management and Systems Improvement – chungate@jsi.com, that's chungate@jsi.com and I will direct your question.

The presentation materials and transcripts will be posted on the National Training Centers website, www.fpntc.org within a few weeks. After the webinar, you will receive an email with a link to an online evaluation, please complete the evaluation by Thursday, May 2nd.

I would like to begin today's webinar by introducing our presenters Tom Dawson, SA Kushinka and Patrice Capan.

Tom Dawson is a principle and founding partner at Full Circle Projects Inc and has over 24 years of experience in the Health IT field. At Full Circle projects, Mr. Dawson promotes the effective use of Health IT in the safety net through program design project management and assessment for evaluation of healthcare organizations and programs.

SA Kushinka is also a principle and founding partner of Full Circle Projects Inc and has over 25 years of experience in Health IT field. Ms. Kushinka's work includes designing innovative methods for EHR implementation and developing tools to assess organizational capacity and readiness for Health IT.

Patrice Capan is the executive director of Family Healthcare Inc a nurse managed OBGYN clinic. She helped start 25 years ago in Denton, Texas. She has over 23 years of experience as a public health clinical nurse specialist. In her role, Ms. Capan sees patients and manages the clinics Title X grants and other grant programs.

The purpose of today's webinar is to cover the steps that a clinic needs to take to adopt electronic health records. Ms. Kushinka and Mr. Dawson at Full Circle Projects will discuss considerations in assessing readiness for EHR implementation. As well as vendor selection criteria of an EHR system and approaches that Title X agencies can take in implementing an EHR.

We will then hear from Patrice Capan at Family Healthcare Inc., a Title X agency in Denton, Texas who will share the approach family Healthcare Inc took in implementing electronic health records. Let's hear from our presenters now. First please welcome SA Kushinka.

SA Kushinka: Thank you, Caitlin, and thank you everyone for joining us today. Tom and I are really honored that you've chosen to spend a chunk of time with us this afternoon learning about EHR implementation and various aspects relating to it.

As their learning objectives would suggest, we are talking about EHR implementation in sort of three segments today. The first is to discuss readiness and what it looks like and why it's important. The second section, Tom will be covering the tasks and activities related to the EHR procurement process and that relates to evaluating selecting and then contracting for an EHR. And then finally, we'll talk about implementation activities and strategies. Of which there are, there are many and there's a lot to cover today so I am going to dig right in. I do want to warn you that again there's a lot of detail here. But I want to assure you that our goal overall is to prepare you and not to scare you. It is an important endeavor that you're about to embark on and we want to arm you with information and tools to get you there successfully.

So I think it would be – it's important to just take a look graphically at an overview of the implementation process. And I am going to refer to this as we go through the presentation as our metro diagram. And while not all of these activities and tasks are necessarily dependent upon one another. Some can be done concurrently there maybe be workgroups devoted to different activities and tasks. The process that gets you from planning to what we're calling go live which is the first time you use the EHR in a live environment in real-time with real patients. That process does follow sort of a linear, a linear approach. And so again, today, we'll be stopping at a quite a few of these metro stops along the way and going into greater detail about them, but this is an overview of the process.

So let's start with readiness, why is readiness so important. I think with all the lessons learnt over the past few years with the HR implementation we've come to realize very clearly that EHR implementation is much more than an IT project. There used to be a time when I think leaders of an organization would be very happy to talk with their IT director and say please go and select and implement an EHR for us because I think that's what we need. Well gone are those days because we realize that EHR implementation is really a comprehensive agency wide process redesign effort. And it really changes the way care is delivered.

The other reason it's important is that all, all of the resources and the time and effort needed to implement and operate an EHR is quite significant. And therefore you want to make sure that you have assessed these readiness factors and have put mitigation strategies in place to address any gaps in readiness.

When we talk about what readiness looks like for EHR we've come up with five key readiness factors for a successful implementation. And this is after many implementations, lots of gray hair as a result of them. But what we see now is that some best practices are clearly emerging and we've summarized them here in five key readiness factors. And we're going to take a look at each one of those individually.

The first readiness factor is strong leadership and engaged providers. This is important because leaders are the ones if you're leading this process. If you're a leader in your agency you're the one that's going to be sort of carrying water for the people that are doing the hard work. You need to be able to help them break down barriers and make decisions around prioritization of resources. You don't need to be involved in the nitty-gritty details but again you need to support those who are involved in the nitty-gritty details.

You have to allocate time for EHR a big mistake we see is that people are assigned to an EHR implementation project. And it's the responsibility is given to them without taking something off their plate as well. So leaders need to allocate time for EHR implementation in order for it to be successful.

And certainly a clinical champion is critical for a success. They are the folks that are going to be championing the system and making decisions and getting the buy in of their fellow clinicians along the way. And again, through this both the clinical champion and the organization leader needs to walk the walk and talk the talk. So if you tell everyone that this is the most important project but are having a hard time making a decision about, for example, purchasing an extra server or hiring a project manager that's going to speak volumes. So you need to lead by example and make sure that the EHR project does have the priority it needs to have.

The second factor is a cross functional team and one that's also empowered to make decisions. The HIT systems that we're implementing today have, have implications that they touch all features and functions and areas of an organization. All departments are affected all staff members and so in a sense the organization is now connected in a deeper way than it was before. And so the cross functional team comprised of people from the front desk from the clinical side, from the nursing staff, from the billing staff, from the IT staff. Those team members are going to act as change agents in their respective departments and they're going to communicate and also receive input from members of their department to influence the implementation team and the way things are going to be done.

The composition of this team can change over the, over the course of the EHR life cycle from. You might have a different composition if you were in the procurement process there tend to be more finance people involved on that team versus the implementation team where you may want more clinical folks involved versus he sort of ongoing optimization team which really can evolve into quality improvement team. But in one form or another this team should be a standing body for the long term.

The third factor, we've identified is effective change management, it's kind of a squishy topic change management. But it's important to keep in mind that even when change is positive, it's really hard.

So there are a couple of techniques that can be used to make sure that you're managing that organizational change effectively. One of them is communication it's critical to managing fears and concerns about their work, how work is going to change or how jobs are going to change during this process. It's important to also define clear goals for success at every interval along the process. Some of the EHR benefits take sometimes months or years to achieve. And so it's important to celebrate those quick wins along the way to keep morale up. And to make sure that folks are feeling appreciated and recognized for their hard work.

And I also think that expectation management is another real key in effective change management. I used to work for an EHR vendor many, many years

ago and it would annoy me that the sales folks would always, you know, try to tell the providers who yes they'll be on the golf course by 3:30 in the afternoon if they use the system. And so six weeks later after they went live with the system and providers are still, you know, struggling, you know, staying after hours to keep up with their documentation. You know they were, they would get very annoyed about that and it was worse than it needed to be, because they had inadequate expectation management and unrealistic expectations being set for them. So make sure that you're honest with your folks and let them know that there is a, you know, there's a light at the end of the tunnel but there's hard work ahead.

The fourth factor is an EHR that meets the organization's needs and capabilities. Tom is going to talk in great detail about how to select an EHR that meets your organizations needs and capabilities. But generally speaking, the EHR selection should be the result of a thoughtful and rigorous process with input from all departments and all disciplines that are affected.

The bells and whistles of the system really need to be balanced with what your organization can afford what it can afford to manage and it what it can sort of keep pace with. It's really important that you think through some of those aspects of EHR system selection.

And just to keep in mind again, this is part of the expectation management as well that no system is perfect. But if you thoughtfully select an EHR that meets most of your critical requirements, for example, most of the family planning requirements or that can meet your (FPAR) reporting needs. If you, if you make sure that you focus on those critical requirements but also understand the system's shortcomings you'll be able to plan for them and mitigate the effect that they have, that they might otherwise have on your organization and on workflow.

And finally, the fifth readiness factor is certainly resources we all know that system purchase and implementation is a very, very expensive proposition. So you not only need sufficient capital to purchase the system but you also maybe interested in purchasing implementation consulting or you may find that you need to do IT upgrades. And you also need resources to cover some

of the reduced productivity that will occur as a result of your providers either being involved in the implementation team. Or certainly getting up to speed and learning the system.

So we often find that while many organizations many clinics will be able to raise grant funds or to receive a loan that will help to pay for the software itself. There are other costs that they really need to prepare for. And sometimes are often unprepared for the extent of these extra costs.

So some of those are staff time again, not only in learning the system and preparing for it but ongoing as you sort of climb the learning curve. There's capital that's required for ongoing operations, many staff will need to have training to be able to meet the demands of the new, the new system. For example, we find a lot of times that medical records staff they transition from, you know, really dealing with paper charts and pulling, chart pulling and filing to becoming more health information managers. And that's a deeper skill set. So that maybe a cost either hiring those folks or actually training current staff, and then certainly the ongoing costs of EHR operation and maintenance which are maintenance fees hosting and licensing fees.

So there are, there are lots of costs beyond just the initial purchase that you need to really think through and plan for in order to make sure that you can be successful moving forward.

So now, I am going to turn the presentation over to Tom and let's see if I have sorry I am having a hard time finding Tom. There you go you're alphabetical. Oh there we go and Tom will talk to you about the process of acquiring and contracting for a system.

Tom Dawson: So we're going to talk about the high level steps along the way for, for how to think about procurement of the system. A lot of times we talked to organizations that know they have to go forward with this but they don't necessarily know exactly where to go what steps to take how to do it, and hopefully what we'll do is we'll touch on those high level kind of steps. There are different kinds of approaches to procurement based on your organizational type your organizational structure size, staffing, resources and

even your location will influence your process. To allow us to focus the presentation we really want to understand how your organizational structure will impact your procurement process. So we're looking at kind of your main considerations for how you're going to acquire the EHR.

For some organizations standalone organizations that aren't part of a bigger organization the EHR is going to be procured solely based on what you need what your requirements are. But for other organizations that are part of a larger organization or that are part of a health system or a hospital system. You're you may not be the primary driving force in selecting an EHR that may done by your hospital or by the health system or by an affiliate.

It's important that you understand that that's a pretty big differentiating point. Also for clinics that are purchasing a system there are options available to join a network or to be part of group purchasing agreement or, you know, Planned Parenthood clinics have the ability to access (Box Ent), which is an organization that is really built to provide EHR systems to Planned Parenthood affiliates. Those options are important to consider when you're figuring out how to acquire an EHR.

The one thing that's really critical is however that whatever your situation the steps that we describe in this process have an impact on you and will matter for your organization. And it's really important that even if your organization isn't going to have the primary ability to. You're not going to be the final selection organization you're not going to be writing the check, you're not going to be signing the contract that these steps are important to you.

So Paul, I think we're ready to move on to the next, yes, so we're going to do the audience poll. So here we want to really understand about you all and where you're at. And we want to break it down into three responses. We want to know are you going to be the main person, the main. Are you going to be the one who's selecting the system for your organization based solely on your requirements; or B, are you part of a large organization are you affiliated with the hospital, are you affiliated with the health system. Who are going to select an EHR for you that you will implement and then see we're not sure yet.

So please answer the poll in the right, on the lower right panel of your WebEx window and we will, we will get back to you shortly with the results.

All right, the poll has ended and now we wait for the final tally. And this is so exciting. So there we go, so we have – wow, we have, we have 30 percent who didn't answer but we have 40 percent who said that they are going to be the primary selector. And seven, seven out of the – out of our participants who are going to be part of the health at hospital or a larger organization that's going to select the system for you.

So as we go forward with the presentation, we will make sure that we that we give you some information as we go that will apply to you either way. And like I said the general theories that we're discussing are really important kind of regardless how you – of how you acquire this system. And we'll let, you know, how they differ as we go through the presentation.

So the first part and as they refer to this in that broad perspective to the EHR team when it comes specifically to the procurement process the EHR team is really going to drive this effort. As I mentioned they will eventually morph into the implementation team as we go forward. And the kind of the critical thing that you understand as we go into the EHR team is that you need to right size it you need to build it based on your organization. So if you're part of a larger organization you can't, you can't skip this step you still need to, even if you're not making that decision directly. You can either influence the decision or you can develop those requirements you can learn about what needs to be done and be part of communicating that tot that larger entity.

So that they're aware of it so that they understand that there are things that you need in a system that are mission critical. So if you're a small organization clearly you don't need to have multiple teams you can have just one team. But you definitely can't leave off the, the executive leadership aspect, there needs to be somebody as part of this effort who's at the meetings who can help you break through log jams and that's going to be your executive member. You need that multidisciplinary representation that SA was talking about with from each of your major departments. Because this

system is going to affect all of them it's going to affect billing it's going to affect clinical it's going to affect operations.

And all those folks need to be at the table to be able to number one in general buy in number two, communicate to all of the staff that aren't going to be able to sit in at the meetings. And number three to help identify those issues that come up with the systems that you're looking at that may impact your success with them going forward.

So needs and requirements are, are a critical piece of, of the procurement process. And there are pieces that will follow you all the way through, through the contracting piece and even through implementation. Requirements describe what the EHR must do. They have to be specific and objective a good requirement the EHR must be on the ONC certified Health IT product list.

Now that's a great requirement because a reasonable person evaluating an EHR can determine whether or not it's true; does the product meet that requirement, yes or no. A really bad requirement but it's a very common requirement, the EHR must be easy to use and provider friendly. We've heard that one over and over through the years but it's very hard to determine objectively whether a system is easy to use or provider friendly because that – the answer's really a matter of opinion it's not a matter of fact. So as you're developing requirements you need to talk about things that can be objectively evaluated and it's a good way to test your requirements at the end of the day. Could two or three people looking at this make an objective decision about whether or not a system met that requirement.

So the full certification process at the OMC has launched and led. It has been great because it's given taken away a lot of the needs of developer requirements in the old days, we used to have to develop requirements. Like there need to be, you know, fields to capture the, you know, the middle name of a patient. Now we have this certification process that takes care of a lot of the basic elements of the system. What's left and the things that we really need to focus on include the specific requirements for your kind of organization.

So a Title X clinic clearly needs to have a way to, to approach patient confidentiality and there is no standard way to do that. Having worked with a lot of family planning agencies and Planned Parenthoods through the years, There are a lot of approaches a lot of things that are seen as a reasonable and not reasonable ways to approach confidentiality. But you need to develop requirements that define what your approach is to confidentiality. Clearly FPAR reporting requirements Title X compliant forms. Definitely spend the time to go through the, the specific Title X requirements. Sometimes vendors even sell specific modules that will provide Title X functionality. And it's important to understand whether the functionality that you're getting is coming through the main system or whether or not you're paying for an additional module to provide that functionality.

So it's important to understand the requirements will follow you through the process and even if you are. The organization that if you're not making the decision yourself if so if so your parent organizations is making the decision for you. Developing EHR requirements is really critical for the change management process, when your staff all agree upon what are the key requirements. And you'll find that if you discuss them that they're may not be agreement first.

That at the end of the day, it widens their perspective, clinicians tend to see the systems from their perspective. Front desk people see it from their perspective, billers see it from their perspective. We need an organizational perspective and developing requirements really develops that organizational perspective.

Also if you're part of the larger organization hopefully you can influence the selection process by setting out some requirements. Just letting your parent organization know for example that you need an ambulatory system that's certified. To be able to access the federal funds that are made available through incentives is an important piece to communicate to your parent organization.

Procure, the first part of procurement is developing vendor proposals and again those proposals are going to be developed based on the, the requirements that you just drew up. If you're a part of the larger organization this part's very different you're not going to be developing proposals you're not going to be finding shortlisted vendors. The most important thing that you can do is communicate your needs and requirements clearly to your organizational leadership and to your EHR project manager. Let them know that these are requirements that you need to be able to be successful if you, if you – if they give you a system that's not certified in an ambulatory environment or that doesn't have the capacity to do FPAR reporting it's going to be hard for you to be successful.

If you are making that selection on your own you want to start with a shortlist of vendors. So you want to narrow it down based on vendors that have demonstrated success with the organizations like you especially vendors with a proven success in your area. Your state region your city, that proven success within your environment is extremely important. Also you want to eliminate systems that just aren't going to fit, EPIC is a great system but you need about a million clinical encounters a year to make it pay, and there's a lot of small clinics that don't fit that bill.

So try to find systems that generally fit the kind of organization that you are. By looking at folks that are being that are successful in the field that's a good way to kind of narrow that down to 3 to 5. Then you want to customize an RFP template and then the information that is being provided along with this webinar you'll find materials that will lead you to RFP templates. And what you need to do is customize those templates to meet your specific requirements.

It's important that you focus in that RFP on kind of three areas focus on, on financial factors so you get them to make a proposal to you. That includes all the modules you're going to need to do what you need to do, show them those basic requirements that you have. And ask them for information relating to their organization.

So if those initial, the initial RFP is focused on gathering that basic information along with technical information about the system. You'll have a good way to do a first pass and understand which of these three to five vendors are appropriate for you. You'll receive proposals back from these vendors you want to eliminate vendors that are not viable based on those proposals, either ones that are just way too expensive or ones that don't have the functionality that you need.

As you go through the process, you need to document issues that emerge when you see a vendor that where you have questions or where you're not quite sure whether they fit or not but you're going to let them keep going. Document those issues because those will come in extremely handy as you move into the later parts of the process.

Don't use proposals to try to understand how a system does certain things how they provide functionalities. But use it to understand kind of the organization of the systems at a higher level.

The next step is to do structured vendor demonstrations, structured vendor demonstrations are, are a way where you're going to actually look at the system in operation. So the way to start that is to document some typical workflows end to end scenarios starting with the clinic or the patient walking into the clinic, and ending with billing and even reporting.

And then document those in steps and develop an agenda that forces the vendor to, to follow your plan. If you let them, if you don't do this with an agenda if you don't do this with scenarios vendors tend to go in and show you their bells and whistles. And bells and whistles will teach you nothing about how well the system works. It's just a lot of flash that will distract you from the real issues. When you show them scenarios based on the workflows that you absolutely need and, you know, things that are specific to your practice. You'll really learn about how those systems work in operations does it take 15 clicks to do a task or does it take two or three.

And those are the things that are going to be really important, and again at the end of these demos you want to narrow it down to no less than two but

hopefully no more than three vendors to go forward to the next part of the process. And that's due diligence, so due diligence is where we take that issues list that we've started at the very beginning. And that we've carried through the demos and we resolved those issues.

So we talked to folks that are running the system again like organizations are operating the system and, and even if you are part of the larger organization that's selecting a system. These steps are important you too can call organizations that have implemented this system and learn about where they ran into problems, where they, where the system is especially strong. So that you can be prepared yourself when you go there learn from others it's really critical.

As your, as you resolve those issues you start to figure out which are the best systems. And as I pointed out no system is perfect but which ones are the best for me. And definitely find two vendors for your final plan your vendor of choice and your plan B. You absolutely need a plan B as you move into the next part of our process which is contracting.

Contracting is, is pretty important because it, it all the promises made by the vendors sales and implementation or sales and demo teams. They can tell you anything they want to tell you but the only thing that is going to be meaningful after you sign that contract is what's in the contract.

The other important thing to understand is that most vendors really don't write their contracts to be fair to the people that sign them. They're made to, they're made to benefit the vendor. So you need to go through that contract, you need to document the things that you need in it, you need to document them tightly when it's relatively well known like you're those requirements that you identified. And you need to be able to be somewhat flexible when it comes to things that are, that are unknown like rollout strategies and future requirements. You definitely want to still include those in the contract. But for example for federal state requirements you want to make sure that the vendor is obligated to meet future Title X federal and state requirements going forward. But you leave it broad if you don't get into details.

So kind of the basics in contracting one of the key points that we want to make and again this doesn't apply to you necessarily if your organizations going to make this decision for you. But it's also kind of important thing for you to pay attention too because you're going to need to talk to the folks in your organization that are signing that contract. And you want them to build in some of these protections for you as well so communicate to them your issues when you go forward.

Every vendor tries to talk you into, into unconditional payments and you need to resist this they'll tell you that you need to pay 50 percent upon signing the contract and 50 percent upon go live. And then they'll define go live of the system as when they have put the stamp on it and mailed it to you and that's, that's not what we want. We want to keep those payments broken down and going throughout the entire contracting process. So that as you go forward, as you start to run into some problems the vendor still has some money on the table that they need to be able to use. To be able to bring them to the table and really help some of your issues, oops, I apologize contract management you need to assign the role of contract management.

Management is somebody in your organization and that goes for any kind of organization. You don't want to negotiate this great contract and then not follow through on the terms to make sure that people actually meet those terms. And then we want to again, you know, in summary avoid arbitrary deadlines, vendor if you have a deadline that you need to be able to get this system in operation. Whatever you do, don't tell that to the vendor, you need to keep that off the table. The vendor will use that against you when it comes to negotiation. So time becomes their tool to wipe you out to hold you out and you need to avoid that and be willing to, be willing to wait in order to get a good deal.

And again, I think the biggest point here is that no system is perfect as you're going through those negotiations what are the things that you can live with. And if you, if you go in and you reach an impasse with your vendor you need to be able to have that second vendor to be able to go to, to make it work. I realize that this is a lot of process a lot of stuff to do but it's absolutely important under any circumstances however you're buying the system that

you pay attention to these details. It's all about change management that contract becomes the final word that you'll use when you when you get past those sales people and get to the implementation people, and rushing through their processes only to the benefit of the vendor.

We're going to open it up for questions quickly?

Operator: At this time I would like to remind everyone in order to ask a question press star followed by the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Caitlin Hungate: We already have some questions in and we'll take a couple now if you have additional questions please either press star one like the operator said or send it to us by chat. This question is directed to SA what kind of training does the project manager need. What if we don't have anyone with an IT background?

SA Kushinka: Great, thank you, that's a great question because I think the whole idea of, you know, again that the EHR is an IT project it certainly does involve implementing a technology system. So there is an IT component. But I think more importantly the qualifications for a good project manager is just someone who is again comfortable with change management. And they may not necessarily have really well developed IT skills you can have someone on your team maybe contract for someone on your team with those sort of hard core IT skills. But what's most important for a project manager is that they think through things and in a structured way they're able to manage change. And that they also have the authority and sort of respect among colleagues within their organization. So they can, they can really help, you know, what is the term grease the skids or grease the wheels I am not sure.

But, you know, I think people skills and organizational skills are really the more important factor here. Tom, do you have anything to add?

Tom Dawson: Just knowledge of the organization and the processes and how things actually work are really important for that role.

Caitlin Hungate: Great. We have another one and this is directed for Tom. What do you mean by an ambulatory EHR?

Tom Dawson: I apologize for that confusing term the ambulatory EHR is one that's used by clinics there are hospital based EHRs that are often selected. And what we find in a lot of critical access hospitals and, you know, organizations that are implementing an EHR that are related to a larger entity is that the larger entity may have picked a system that's a hospital system. And that's not going to work for an ambulatory organization. There are different processes different operations.

So if you go to the ONCs Health IT website when you look at look for clinic or EHRs that are certified they'll give you two categories one is hospital based one is ambulatory. And you want to look at ambulatory and you want to look at ambulatory. And the good thing about that if you're part of that kind of a dynamic is that most of those hospital based systems either have modules or, you know, vendors that they work closely with. That do have ambulatory components. So you'll be able to use those successfully.

Operator: Again to ask a question over the phone that is star one on your telephone keypad.

And you're first question comes from the line of Tapestry Health Systems. Your line is open.

Male: Hi, I am just curious what in your experiences is a realistic timeframe from the time you start looking into a EHR to the time you actually go alive.

Tom Dawson: I think the fastest that I've seen it done effectively is four to five months. And it can go longer than that but I'd say that the average maybe goes between those five months and that seven or eight months. You can keep it, you can keep it quick but going any quicker than that and you're going to lose some important pieces.

Male: OK, great, thank you.

Tom Dawson: To the point where you go live, I think it will take you a while to do that contract. The contract, contracting can often times be one of the longest parts and it's the real riddle. Because it depends on how, how willing the vendor is

to negotiate a fair deal with you. And if they're willing to come to the table in contracting you can move pretty quickly. And there are a lot of really good vendors out there that will but there are a lot that will play every game with you in the world. To try to get you to sign a contract that's that isn't in your best interest. So that's really the hard part to giving you a timeframe from the beginning of procurement to go live itself.

Tom Dawson: OK, OK, great, thanks.

Operator: There are no further questions in queue over the phone. At this time, I turn the conference back over to our presenters.

SA Kushinka: Thanks very much. So I am going to talk about – again, we're going to revisit this metro diagram and let's talk about the actual process of implementation. And now that we've got our carefully and thoughtfully selected EHR system with a good solid contract and lots of protections in it for us.

You know there was a time when we presented the EHR implementation process as just that metro stop diagram. But what we came to realize is that is that while leading up to go live the tasks and activities are rather predictable and linear. And they do follow a methodology that once you go live the process becomes much different it really becomes more of a QI process.

And so if we were to really to be realistic about this, you know, the I think the metro stop diagram gives the impression that once you go live then you pop the champagne corks and you live happily ever after and everything is fine. And really nothing could be further from the truth in the sense that the activities of implementation do not end there. And in fact they sort of begin a new, a new cycle. So if the metro – the last stop on the metro was the, the dot that's in the lower left quadrant in that innermost dot, what really happens is that once you go live you start tweaking the system you start improving it and optimizing it adding more advanced features and functions adding more users and it really becomes more of a QI process.

So I want you to keep that in mind because it does mean that implementation is rather continuous. But it is a more realistic way to look at what happens, so again stopping at some of these stops along the way one of the most important

things you can do in the implementation process is workflow analysis. It's really an iterative process you do it before, during and sort of after that major part of implementation after go live. And we always say automating a dysfunctional process only makes bad things happen faster.

So please pay attention to what we call your current state what's happening now. Try to reduce as much waste and redundancies and try to standardize as much as possible across your organization. Because what happens again if you put a technology system on top of that, on top of chaotic processes. They're only amplified or magnified and the EHR system often becomes the scapegoat for that when in fact it was the underlying process that needed to be reformed.

And also pay attention to paper forms and the actions that they trigger because very often those forms are going to go away in the new electronic world. All right, workflow analysis, why don't we just talk about that, OK.

I am just quickly – I put in here very often, we use workflow diagrams or flowcharting diagrams to depict a process. So this is a pre-EHR medication refill and here's a post EHR medication refill. And it's really nice to see this sort of dramatic, very dramatic graphic example of how a process can be streamlined. And these process flow diagrams are also very important and can be very effective in training. The next stuff we're going to talk about you'll hear the word configuration a lot when talking about EHR implementation.

So modern EHRs are really toolkits and you by virtue of populating different dropdown lists and files and master files and templates. You can actually sort of customize the system without doing, without having the vendor doing any, any custom programming changing the program code. And so that's really where the implementation team is going to spend most of it's time.

Now if you're inheriting a system, if you're the beneficiary of the system from a larger organization, a lot of the heavy lifting will be done for you. But it's still important to go through and carefully understand how the EHR has been

configured. And negotiate to be able to insert some of those configuration details that will help you more fully use the system.

I also want to talk about data conversion, this is a really big issue because you do have a lot of data right now in your systems probably and some are electronic systems most of the organizations we work with have an electronic practice management system which is your patient data base with the demographics, has your appointment data in it, your billing data, but most of the, most of the clinical data is still in resides in paper charts. And so the process of getting that clinical data into the electronic chart is called chart abstraction. And there are a number of different ways to do it and I truly do mean that I could talk for an hour on this topic alone.

And since we're running short on time, I think what I am going to do is just point you in the resources that will be provided to you after the webinar. We've written a short issue brief that really outlines the three basic methods of chart abstraction and data conversion which are scanning and electronic computer to computer transition or manual data entry.

And it's really important I think to thoughtfully consider how you go about this and talk with your providers as well because they have a pretty deep seated reluctance to let go of that paper chart and be kind to them as they evolve and work through the process and let go of that paper. And really only enter the critical data into the new system.

The next step is that you want to pay attention to is system testing once you get your system configured and workflow analyzed and data converted you definitely want to test your system before you go live. So you don't want those bugs or glitches or unpredictable things showing up once you're actually using the system in a live environment.

So spend some time here and also try to we recommend getting folks having a period of time where, you know, you get a maybe 10, 15 minutes where you get all of the folks in your organization on the system using this system in not in a real environment. But most vendors will provide sort of a sandbox or a testing environment. And get on the system and try to do a few things just to

see how the system forms under pressure, under maximum usage so that you can minimize any performance delays in a live environment.

Training is perhaps the most important aspect of pre-go live activities. I worked with a health center in Northern California that did a really nice job on their implementation and I asked the project manager who is a QI nurse what her secrets to success were and she said I have three, training, training and training. So it's really, it's really important clearly you need to take the approach that training is an investment not an expense the cost of people using the system improperly is way more than the cost of training them, I guarantee you. And don't, don't think the vendors going to swoop in and, you know, provide you with great training materials, they'll provide you with some that you can customize but you'll really need to train according to how you are going to use the system in your environment.

All right, an important part of training and testing is a mock – conducting a mock clinic and we recommend this highly. It's an opportunity to either after hours or at the end of the day close the clinic for an hour too and really role play conduct an end to end visit a typical visit family planning visit a preventative care visit. Walk through it and really and then debrief afterwards many, many things will surface out of this, out of this process. And it can be extremely helpful.

All right, so now you're tested, you're configured, everybody's ready to go live. Go live is a very stressful time, it can be chaotic there's lots of disruption, again people are fearing change but it also can be very exciting.

If you've gone through the processes we've talked about to help minimize the disruption, if you have a have solidly configured and tested system, you've redesigned your workflow and you've had good training and communication.

There are couple of different methods that people use to go live one of them is called big bang. So this is like especially for a multi-site organization this is where all clinics all sites go live at the same time. Sometimes it even includes the practice management component and this, this is that's sort of what I call nuclear bang. It's again it can be, it can be pretty stressful but a lot of

organizations for example that have patients that move from site to site. This is a very, you know, important, you know, they don't have an option of doing it any other way. This is really dependant on a high level of what we call at the elbow support for providers. We've seen people be effective with this but they have had an armada of support both internally from the vendor and from consultants.

More typically, we might see an incremental rollout and there's a number of ways you can incrementally role out you can pilot at a small site get the bugs worked out and move to a different and then move to a different site or a larger site. You can rollout feature by feature, for example, you can implement e-prescribing first and then orders second. And then clinical documentation last and do it sort of slowly. You could roll out department by department you might have OB first, you might have Ped second, if you're a primary care clinic that sort of thing.

And then there's also a method called fractional days and that's where you, you can select a few patients that say I am going to document on two patients in the morning and two patients in the afternoon. And then increase that gradually as you go along. And keys to success with this approach all these incremental approaches are really it requires very careful workflow design and careful thought of to where the most recent clinical information resides because the information will be split between the electronic chart and the paper chart, so that's a little, that can be important to really, really draw out for folks.

So regardless of how you implement, again, thinking about that spiral diagram, we really encourage you to set performance standards, monitor them. And then provide focused training for your providers who are falling behind. (Inaudible) what I call evidence based implementations set measurable objectives and then celebrate when you achieve them along the way. And just to keep in mind implementation is continuous, don't be afraid of that it's a good thing.

Implementations, lessons learned, very quickly I'll let you sort of read those. I do think that again it's really important to take ownership of your system early on and use your vendor as a partner but remember it's your system.

And again, keep in mind that while the pre-implementation activities follow that sort of metro stop approach very linear. That afterwards really there's a lot of one on one support that goes on, make sure you don't skimp on training. And again, set goals for organizational usage and monitor that performance and coax your providers and your staff forward and you'll be successful.

So with that, I would like to your reward for listening to all this detailed advice is to hear from Patrice Capan at Family Healthcare, and we've had an opportunity to speak with Patrice in preparation for this call. And I think you'll find that her experience has been not only practical but inspiration as well. So Patrice, I'll turn that over to you.

Patrice Capan: All righty, well good afternoon everyone. After hearing that dramatic (in flow), I want you to know it is OK. Actually I ended up doing exactly what they said to do without knowing that that that's what I was supposed to do which is certainly encouraging to all of us.

My clinic is a non-profit. I am the executive director of it and started 25 years ago like they said, I am also a clinical nurse specialist. And so by being that I was able to figure what we needed from a clinician's standpoint as well as from an executive director kind of standpoint. My staff is of 15 staff members, two medical directors, six nurse practitioners, we do about 1,500 visits a month, half of which are OB and half are family planning.

I have Title X funding and several other grants. We serve mostly the uninsured about 900 pregnant women a year; 3,400 family planning. And we accept any pay or source that will accept us private insurance Medicare, Medicaid PPO all of that.

As far as how we funded an HER, I am still working on that. Part of it was initially to where she's just using a credit card because you've got to go out and figure out what computers you need which ones are too slow laptops that sort of stuff a good scanner. But what is each state is different apparently

from what I've discovered but we went live April 11th, so 90 days after going live, I will be able to apply through Texas for their incentive payment plan. It will proving that we saw at least 30 percent Medicaid. And then I am supposed to get about $21,000 per provider back. So that's what's really going to help me pay for this whole system is my hope is that much money will cover everything that I've been spending on.

Now the staff involvement, it's been since day one, I've been researching this for about a year now checking out all the different EHRs out there having all my staff when they go around to different clinics for their appointments and stuff. To ask how they like theirs what they don't like and then we've been compiling that information. And then after checking out with different vendors, I narrowed it down to a couple of them. Had them come in and make presentations to my whole staff at lunch time and of course they always feed you which is a nice plus. And after they left, we would sit around discussing the positives and negatives.

And like SA was talking about the bells and whistles, you try not to get turned on by all the bells and whistles and realize what will make us efficient, user friendly, 24x7 support, to be able to redo the templates that you need. Because some of the systems, you know, you have to go put it in writing and wait a week or two to get the templates changed. I took all of that information had to present it to my board and many of them thinking this work in the healthcare field. So they had a lot of input and good recommendations.

And then part two is, of course, the age of your staff. My staff goes from 23 years of age up to 65. So there's a lot of common anxiety when you're talking electronic stuff to us old people but they were on board with it and so the team ended up being just me my office manager, my administrative assistant so three of us out of the 15. My administrative assistance is pretty good with billing and IT, so that was the group that helped set up the initial system with the going through the billing and templates and that whole deal.

Now far as the like the data conversion, we chose not to convert everything, it was like as they were saying you've got 25 years worth of old patients with old data. And so my staff was onboard with wanting to do all fresh with

everybody. So my front desk and my lab in their downtime, what they would do is just take patients from the old system to put to the new system and we're booked about 90 days. So they put the demographics as well as the appointments in the new scheduler, so they weren't having to work off of two schedules. So basically we went with the PM side first and they'd love the point map scheduler and stuff. And they also learnt where all the fields were and what information was in there.

Then after that most important thing that you've got to remember is what is going to be your target live date. Now unfortunately, I kept having to move my back some but that date is so crucial because you got decide like blocking patients because you're going to have to double the time for patients in order not to trash everybody.

And so part of it was also that I would block three mornings in one month for like two hours each time for the month before we went live so that we could do the practice patient run through. So one of this was an annual, one a pill refill, one a problem patient and started just like a patient would at the front window going all the way through in the normal way and what papers you'd have to fill out.

So the first time was a horrible chaos, we didn't realize how much we didn't know and that we didn't have a smooth system in place. So that by the third run through everyone's anxiety was down they were pretty comfortable with the whole system and we'd set up systems like what do you do with the consent forms, where do they go. Now what paper you actually had to have or not have. And then I also began with just our pregnant patients, so that that way I figured it was only like blood pressures and weights and some P that you had to chart instead of a whole family planning annual and that worked well.

And then three weeks later, so that was just April 11th, we went live with everything and it really hasn't been that bad. I have one practitioner that's pretty traumatized, so I am still letting her chart on paper and then enter it later in the EHR because she just gets too worked up about it. And, you

know, you just have to realize it's really not that big a deal but just don't make everything an absolute and it's worked out actually pretty well.

The most important thing you need to meet probably almost every day at lunch to discuss what issues you had during the morning because I didn't do that until now. We were meeting, you know, at least once a week but I think we really need to discuss everyday to clarify because people don't know where to put things in the template. You don't realize where the problem go what are putting on the problem with that sort of stuff is instead being very confusing.

And you've got to realize you're going to have to schedule twice as long for every appointment. That your revenue's going to go down, so that means like if you normally have a 15-minute appointment you make it 30, if you have a 30 minute, you make it 60. And I've done that for six weeks and we'll see if it was long enough I'll let, you know, later. And with our system that I chose it's there's no live trainer. So that was where I went with the cheaper one as far it's the month to month and that way I am not commitment to $80,000 upfront and they've got to keep me happy. So if they're not, then I can delete them without having lost anything but a whole lot of time and that's worked out really good.

But it's the important part was the training as far as they have modules online 24/7 that my staff could go and watch everything. And I also give them at work to watch like a group for all the lab to watch at one time all the front desks all the practitioners. So then we could talk to each other about, you know, what did you think about what that. Where did we put the blood pressure or the pill refill, I mean all of those kinds of issues that come up.

And that has worked quite well, the most important part was before we started I said you got to have a 100 percent commitment guys. The weak links because it's just one person who doesn't do their homework and knows how to do this will really mess it up for all of them. And they were all committed to it we've actually I think become more cohesive. As far as the younger ones, of course, learn everything much faster and so they're able to say "Hey

there's a shortcut" or "This should go here." And it just makes it so nice to have everyone sharing their little knowledge that they get it.

And the thing that I really like about the system. front desk loves it completely because you see like five providers patients at one time. It will confirm the insurance Medicaid all of that immediately, it shows green if it's confirmed; and red, if it's denied which is pretty neat.

For the clinicians, you know, there's instant reminders in there about abnormal paths, abnormal lap follow-ups. I made one for the age of the client if they're under 17, there's a window that pops up to remind you to deal with the minor questions that you have to ask.

There's (inaudible) billing, so that you have to have in all the codes before it goes through or these little popup windows saying missing a field, missing a field until you fill it out correctly. There's all kinds of neat reports available for the revenue generated like practitioner by clinic. I'm sure there is still bunch of it that don't even know are available. There's no more lost chart like Wednesday nights, we had a 125 patients charts to pull. So all the data's at your fingertips.

My medical director's love it because they're able to review charts from home, they can send us messages for follow up care like the labs. And I love it because I can read their handwriting so I am not having to try and figure out what they said and it's all right there in that patient's note. So also that has honestly been a real plus. Now advice for you all well may the force be with everyone of you.

The most important thing is to know when your live date is going to be because everything else has got to be set up. You got to have your time blocks for practice you've got to have the patient appointments doubled and be ready to lose revenue. There's no way it's not going to get out of losing revenue there. And I love being able to make constant tweak on the templates. I mean someone doesn't like the where a pap smear goes on some form I go into my office and I move it from the top to the bottom that's really a real plus.

Make sure your internet's strong enough I didn't even know if that was a question I needed to ask. But I needed to change to a new provider because I needed more download and upload speeds. Support for your system that's the most crucial of everything if you have a problem you can't log on. You can't find where something goes in a template or whatever that supports 24/7 and also I think they should be US based there are many that are overseas. And when you're dealing with this sort of electronic stuff that I don't even speak the language very well.

If you can't communicate well it is very frustrating so lab interface you don't even understand whether it's a whole new vocabulary what is a lab interface. You know that whatever lab you're using that the lab will populate right into your electronic record. If you have an interface but you've got to pay for it and so be sure in your contract, you know, that the lab might charge you your EHR might charge you. And then there's a monthly fee for it, and so we've only used the one big one to interface with the others so you just have to manually put in the labs as you get them back. But those are all of my issues and my traumatic life, I didn't realize this was on my bucket list but thank god I've God, I've got it checked. So that's it questions anybody?

Operator: Again. if you would like to ask a question over the phone. it is star followed by the number one on your telephone keypad.

Caitlin Hungate: So this is a question for Tom this came in via the chat. We have very, very small family planning clinics on the line. For example. one clinic sees less than 400 patients per year and operated with 2.25 FTE. Does the clinic this size generally have the capacity to implement an EHR what should we look at to assess readiness?

Tom Dawson: I think the ultimate decision about whether or not to, to go with any of the HRs they're going to go with the clinic. There are certainly systems that are designed for small practices, for single provider practices. So there should be no technical or no, there should be no barriers to you going to EHR. But you definitely need to look at your organization you need to make sure you've got the internet connectivity that you, that you need. Because you don't want to host the server, you don't want to, you want to be able to use a system that is,

a system that's available in the cloud. So an internet-based system. And for that to work you need to have solid dependable internet connection.

But there are a lot of systems out there that are designed to be delivered that way. You don't get as many choices there are less bells and whistles with those systems but they're easier to implement and operate. So, you know, look at the kind of system that you end up selecting, you may not be able to select Next Gen. But there are plenty of good internet based systems out there that you can that you can work with.

Caitlin Hungate: And just to remind everyone you can chat your questions in via the chat box or also via the operator. This question is directed to Patrice, did you have a mentor or someone who has been down this path before to help you.

Patrice Capan: If only, no, it was just me trying to do my due diligence and just again, I was just on the internet reading and talking to everyone who had an EHR and AdvancedMD. Was the one that I went with because of a small clinic setting and a month to month and it was one of the least expenses that I have no complaints about it. So no, I did not have a mentor unfortunately.

Operator: There are no questions over the phone at this time.

Caitlin Hungate: OK, here is another one from the chat and this is directed to SA. How do I get my lab information into the system?

SA Kushinka: Thanks for that question, you know, that's a really important question that we didn't really address in the formal part of the presentation. But usually as Patrice talked about, the lab information can come in through an interface which is essentially two computer systems talking to each other.

When it worked properly, it can be a tremendous timesaver for providers and staff alike. So you can typically order your lab, order your labs as a result of your clinical documentation and the plan of care. And then you receive the results back into your EHR and usually they come into a provider inbox. And it's great for the provider because they can typically just a kind of sort of review all the labs at once and check them off as reviewed. And then follow up on the ones that are, that clearly need attention. But it's a great, it's a great

timesaving, time saver and providers love it. And it's one of those things like the low hanging fruit that really get them excited about using the system.

And, you know, again typically that takes a little bit of testing and trial and error to, you know, make sure that those labs are coming in and there's no there's no delay. Or they're being matched to the right patient and then when the results come in etcetera. But I think certainly from Patrice's description I think that's a big timesaver for her. And typically what we see is that some, you know, you don't, you may not have an interface with all your lab vendors. Some will still probably come in on paper through fax and have to manually enter them. But when we can get to the point where, you know, all the majority of the labs are coming in through an interface it's really a tremendous efficiency, efficiency, you know, builder.

Caitlin Hungate: Great. Here is another question that this is directed to Patrice, what systems or protocols do you have in place in the event your server goes down or even a natural disaster happens. And Tom and SA, if you want to speak to that in terms of advice for other clinics as well, that would be great.

Patrice Capan: At this moment, absolutely none, I am still trying to figure out how to do it all, I am sure over the next couple of months we'll figure it. So far, it only went down once and that was before we had gone live, so we were very lucky, but no I don't have any protocols or anything in place yet. So SA and Tom, take it away.

Tom Dawson: I think that what's really important is that you have a plan for what to do if indeed there is an internet outage and your unable to reach your server. So you don't want to cancel the clinic, you want to have a plan so that you can go ahead chart manually and then go back and enter that information into the system later. Even printing out, you know, summaries before and at the beginning of the day is helpful to have a guide in-case there is a disconnect. If you have the resources to do it some clinics will build a redundant system to reach the internet. So they'll have two different internet connections in case one goes down that's another option as well, but it does require resources.

Caitlin Hungate: Great. And just to let everyone know a few questions have come in through the chat about resources. The resources and a copy of the webinar will be uploaded within a few weeks to www.spntc.org.

And here is another question from the chat because of most of our Title X, Title X clinics are not associated with CHC. They must be see more than 30 percent of Medicaid patients to meet meaningful use for incentives for Medicaid, Medicare. Because of low number of Medicaid patients seen which is around 6 percent in this case, demonstrating meaningful use maybe ways off. Generally, do you find that that an EHR is worth the investment?

SA Kushinka: Well I think maybe in a few weeks, we should ask Patrice about that.

Patrice Capan: No, I'd say, yes, I mean I'd say 4,300 a month which is doable, so it's not outrageous.

SA Kushinka: And I would add to that that even, even without the meaningful use incentives or if meaningful use incentives are a way out in your future. We are beginning to see that as more and more organizations are able to collect data electronically and then share data electronically. That coordination of care is much improved that efficiency of care delivery is much improved. And while, you know, we're not probably making as much progress or as fast as we had hoped in theory that we will really be positioned to do all sorts of things in the future that require the collection storage and transmission of data electronically. Just comparative effectiveness research and so many things that will improve our healthcare system.

So I know that sometimes the benefits realization horizon is far off in the distance but, you know, I am a true believer I've dedicated my career to it way before meaningful use incentives. But I am not, I am not going to prepare that it's not a tough slog.

Tom Dawson: Also it's important to add that, you know, that things are going to change at the end of the year. In the 2014 when the affordable care act is implemented there will be a Medicaid expansion so there may be more Medicaid patients and you have until 2016 to implement under the incentive program. So even

if you're not seeing a percentage of patients that would allow you to qualify for incentive now keep it on the radar because you may be going forward.

Caitlin Hungate: Great here is another question directed to Patrice, did the EHR system you chose have a Title X module. Or did specific programming need to be done to capture Title X data?

Patrice Capan: Well I actually had to upgrade my templates to collect the data but AdvancedMD worked with a second group that created the actual report my FPAR report data. And a couple of other grants that I required and so it's all – it's just all one little custom tab all the stuff I need to put in. You know they're ending birth control methods, income level all of that is right there.

So the beauty is that they've told me is I can share my templates with anybody so that all of the work I've done it can be shared and now that they've got an FPAR report created that's pretty neat as well so yes, it does.

Caitlin Hungate: And this is a question for SA, can you talk a little bit more about chart conversions what approaches tend to work best for family planning clinics.

SA Kushinka: Thank you for that question. I love the topic of data conversion and chart abstraction. I think, again, you need to look at how the data that you have now is collected where it resides how healthy it is. In other words how accurate and up to date it is.

You know generally speaking the if we just talk about the clinical data which is captured in the chart. I think what works best and again you have to really sort of work with your providers and assure them that things will be OK and that the paper charge is not going to go away. But really just the most recent information is what works best to convert. And sometimes this does mean that you, you have to have someone either the provider or the, or some knowledgeable members sitting down and actually keying in some critical data. You can, you can scan information in like the last progress note or some maybe consult notes that you might have had from an external, you know, referring provider.

But you have to keep in mind with scanning rather than just scan in the whole paper chart that its' just a picture of data it's not really, it's not really data. It's great for access but if you for example scan in a Pap Smear report and then you try to go and run a report out of your EHR system that says show me all patients overdue for a Pap Smear. That's not going to show up because that data in there was just a picture and so it doesn't know the date, you know, that your system does not have a way of knowing what date that report came through. So you have to think about what the data is going to be used for in the new system.

And again the health of the data that's coming from your old system into the new system. And then typically, you know, with all even with family planning clinics that, you know, certainly for clinics that provide a lot of primary care this is an important issue. But again even for family planning clinics you're still probably going to want to pull the paper chart. And maybe Patrice might have some advice for us on how their clinic did it. But a lot of groups that we worked with have said look we'll pull the paper chart for you for the first two times you see the patient. And then after that it's totally electronic and if there's something that's not in the paper chart I mean I am sorry not in an electronic chart that you want. You can tab it and, you know, flag it and someone will scan it in for you. So you have one last sort of opportunity to get that data from the paper chart into the electronic chart.

But typically when you, when really hard pressed most providers look at one or two key things in a chart at the start of a visit. And if you can get them to kind of, you know, realize that then they're more willing to let go of the paper chart and then, you know, move forward. But having some key data in is really, really critical. It will help, you know, so the it will help you regain your pre EHR productivity. So the providers aren't going between you flipping through the paper chart and then also trying to enter something into the electronic chart while the patient is being seen in the room.

Tom Dawson: One thing that I've seen in working with Title X clinics is that because patients tend to kind of come and be with the clinic for a while and move on. That a lot of them look at that as a factor when they develop these data strategies.

I am thinking of one particular client I worked with that had a database that had 15 years worth of patient data. And they really decided that what was the most important was to, you know, save the data from patients who had an active visit in the last three years, so that they didn't move a lot of unnecessary data into that new system.

And I think that's thinking about what data you currently have, how much of it you want to use and how much of it you really want to move into your new system is an important factor that Title X clinics should pay attention to.

Caitlin Hungate: Great. Here is another question for Tom, what are the technical requirements we need to know about?

Tom Dawson: I think the main thing there is just to understand how the, how the EHR is going to be provided. So does it require that you have a server on your side in your building, is it something that's a web based system, what does that mean and then each system will have technical requirements that will give you. You need to have computers that can that have this level of configuration, you need to have internet access that meets these parameters. And those are things that you can ask for in that proposal.

But those are really the kind of the key things to understand really what is it going to take for us to successfully operate each system. And, you know, each vendor when you communicate with the vendor. Give them your profile tell them who you are and what you look like. And if you're one of those practices that has, you know, three FTEs, they'll know enough to send you information on their web-based system. If they don't have a web-based system they're not somebody that you want to consider.

Caitlin Hungate: Are there any questions on the phone?

Operator: At this time, if you'd like to ask a question through the phone line please press star then the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

And there are no questions in queue at this time.

Caitlin Hungate: Here is another question for you. Are there any best practices to minimize the risk of staffed turnover. We heard about a clinic that invested a lot of resources in training their team only to have several people leave shortly thereafter.

SA Kushinka: Well, I'll this is SA, I'll take that question and then I don't – Patrice hopefully, you haven't had any experience with that.

Patrice Capan: No.

SA Kushinka: But if you had good, well sometimes, you know, I think that that it's certainly always a risk. Again, I think I mentioned I used to work for several EHR vendors many, many years ago. And, you know, some of our we, you know, we used to some people actually enjoy the implementation process and activities so much that they would actually want to join our staff. And we always felt bad sort of poaching people from, you know, from our clients but, you know, as people just, you know, move on in their career development.

Turnover is certainly a factor, I would say that you definitely, you know, having this multidisciplinary team sometimes will mitigate that risk. Say if one team member leaves then at least there's some sort of organizational history. You know they're not sort of walking out the door with the organizational knowledge until you can find someone you know. You can find someone to replace them. But again I think this is why the change management piece is so important and really can't be ignored, you know, sometimes people leave a clinic because they just can't take the EHR. But, you know, really there's no place you can, you know, eventually we are all going to be electronic. And so paying attention to people's attitudes and taking queues, you know, from their behavior can help you to address areas where staff maybe dissatisfied.

You know typically we might hear like someone saying "Oh I hope management knows what they're doing." You know like there's the sort of us versus them, you know, environment being set up. So that must mean that that person doesn't feel like they're part of the process. And so what can we do to, you know, engage that person more in the process.

But in the case of, you know, having people, people trained and then having them leave. Again the only thing you can do is make sure that, that knowledge about the system and about how it works, resides in more than one person. So that you're not vulnerable to, you know, to the staff turnover situation. But that does occur.

Tom Dawson: It's really important when you're, when you're training in the system to, you know, not let people hide out. You know they have to be part of it they have to bring in people to when you're building the schedules you don't want to. Just like you do now you don't want to train one person to do it and then find yourself, you know, out of luck when that one person leaves. So there always needs to be, you know, multiple people trained in how to work the system. And it really does require that organizational transformation. People have to take responsibility for it, you know, document what you've done and pass it on. So that it becomes an organizational asset rather than something that's associated with. Like one particular angel who's keeping the EHR up and running.

Caitlin Hungate: Great. And we have one final question in the chat before we wrap up. If a clinic does not meet the recommended requirements for EHR implementation, would such a change be unadvisable?

Tom Dawson: I am not quite sure that I understand that, if you're talking about an individual vendor. If you're looking at their system and you're not a good, if you're not a good candidate for their system then, then don't implement that EHR. But there are a lot of EHRs in the marketplace that have been built especially for, you know, very small organizations single practice organizations, single provider organizations. So there should be systems out there regardless of your organizational size that, that you should be able to fit within. If you're in an area that doesn't have internet access and that doesn't, you know, that's a, that's a very difficult, a very difficult issue to deal with. But there are still systems that exist that are meant for small environments and you just need to choose carefully those vendors that you consider so that they fit that mode.

Caitlin Hungate: Great. Thank you. Are there any other comments Patrice or SA that you wanted to contribute?

Patrice Capan: No, I can just say that I am glad we did it and it hasn't been as traumatic as I thought it would be.

SA Kushinka: And I would just like to …

Caitlin Hungate: So thank you so much every.

SA Kushinka: I just wanted to wish everyone luck and I think Patrice is a great example of someone who boldly moved forward and got through it and will reap the rewards and I wanted to just thank her for her inspirational story.

Patrice Capan: I'll keep you posted.

SA Kushinka: Please do.

Patrice Capan: I have still time for breakdown.

Caitlin Hungate: Great. This concludes the webinar. Thank you so much everyone for participating. And you should receive in your inbox an evaluation of this webinar. Thank you very much.

Operator: This concludes today's conference call. You may now disconnect.

END