



RESOURCE AND PATIENT MANAGEMENT SYSTEM

RPMS- EHR for Meaningful Use - Stage 1 Training

July 8-11, 2013

**IHS Office of Information Technology (OIT)
United South and Eastern Tribes (USET) Regional Extension Center
Alaska Native Tribal Health Consortium (ANTHC) Regional Extension Center**

&

Southeast Alaska Regional Health Consortium (SEARHC)

Purpose of “EHR for Meaningful Use” Training

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

The CMS EHR Incentive Program provides incentive payments to eligible professionals (EP), eligible hospitals, and critical access hospitals (CAH) participating in Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use (MU) of certified EHR technology. This course attempts to describe and explain the initial criteria that EPs, eligible hospitals, and CAHs must meet in Stage 1 in order to qualify for an incentive payment.

Ultimately, meaningful use of the RPMS certified EHR technology should result in health care that is patient-centered, evidence-based, prevention-oriented, efficient, and equitable.

Though some functionalities are optional in Stage 1, all are considered crucial to maximize the value of certified EHR technology to the health care system. Many, if not all, of the optional functionalities will be included in Stage 2 and beyond. EPs, eligible hospitals, and CAHs should be proactive in implementing all of the functionalities in order to prepare for later stages of meaningful use, particularly functionalities that improve patient care, enhance the efficiency of the health care system, and promote public and population health.

Prerequisites

Physicians, Pharmacist, Nurses, Health Information Management, Information Technology, Performance Improvement, Case Management, and other Health Care Professionals responsible for Meaningful Use Performance and Clinical Quality Measures. There is no requirement to designate an MU coordinator, though hospitals and larger clinics and practices may realize operational benefits from doing so. This class will be oriented towards the MU coordinator for the facility or practice. This course assumes that participants:

- Are Intermediate to Advanced RPMS Users
- Have experience with the EHR at patch 7 or higher including all dependent patches (which can be found on the agenda appendix) & verified with Area CAC

Background

On February 17, 2009, President Barack H. Obama signed the ARRA into law. ARRA provides incentives to encourage hospitals and office-based physicians to adopt EHRs and other health information technology (HIT) solutions that reduce costs by improving quality, safety, and efficiency. ARRA contains numerous technology and privacy provisions with aggressive timelines for completion. Many of these ARRA milestones relate to the standards and work of the Healthcare Information Technology Standards Panel.

Health Information Technology for Economic and Clinical Health Act

The Health Information Technology for Economic and Clinical Health Act (HITECH) is a focal point of ARRA and represents an investment of more than \$19 billion towards healthcare information technology (IT)-related initiatives. The \$19 billion dedicated to HITECH is divided into two portions: (a) \$17 billion toward a Medicare/Medicaid incentive reimbursement program for both healthcare organizations and providers who can demonstrate “meaningful use” of an approved EHR; and (b) \$2 billion available to providers located in qualifying rural areas, providers serving underserved urban communities, and providers serving underserved Indian tribes. Meaningful use of an approved EHR is required in order for providers to qualify for, and continue to receive, incentives.

Incentive Payments

ARRA will provide incentive payments through Medicare and Medicaid reimbursement systems to encourage providers and hospitals to adopt EHRs and HIT. Incentive payments are triggered when a provider or hospital demonstrates that it has become a “meaningful EHR user.” The highest incentive payments will be granted to hospitals that adopt EHR technology in the years 2011, 2012, or 2013. Reduced incentive payments are granted to hospitals that adopt EHR technology in the years 2014 or 2015, while no incentive payments are granted to hospitals that adopt EHR technology after 2015. Providers and hospitals that fail to meet this time limit will be subject to penalties in the form of reduced Medicare reimbursement payments beginning in 2017.

Meaningful Use

Meaningful use is a term used by the Centers for Medicare and Medicaid Services (CMS) to ensure that providers and hospitals that have adopted certified EHR are using the technology to further the goals of information exchange among health care professionals. EPs (eligible providers) and EHs (eligible hospitals) will achieve meaningful use if they: (a) demonstrate use of certified EHR technology in a meaningful manner, (b) demonstrate the certified EHR technology provides for electronic exchange of health information to improve quality of care, and (c) use certified EHR technology to submit information on clinical quality and other measures.

Achieving meaningful use will be accomplished in three stages. Stage 1 will begin in 2011, Stage 2 will begin in 2013, and Stage 3 will begin in 2015. The criteria for achieving meaningful use will increase with each stage and will build upon the prior stage. Medicare and/or Medicaid incentives are available to providers and hospitals who become meaningful users of certified EHR technology, with the maximum incentives being given to EPs and hospitals that become meaningful users in Stage 1. Hospitals may be eligible for both Medicare and Medicaid incentives but EPs must choose between the two incentive programs.

In order to achieve Meaningful Use, an EP must report on 15 core performance measures and 5 out of 10 menu set performance measures simultaneously. One of the EP's chosen menu set measures must be a designated Public Health Objective. Eligible hospitals must report on 14 core performance measures and 5 out of 10 menu set performance measures simultaneously. One of the selected menu set performance measures must be a designated Public Health Objective.

For demonstrating Meaningful Use through the Medicare EHR Incentive Program, the reporting period for the first year is any continuous 90-day period. In subsequent years, the EHR reporting period is the entire year. Under the Medicaid program, performance measures and incentive payments may be awarded for merely adopting, implementing or upgrading certified EHR technology. Consequently, there is no Medicaid reporting period for year one – all subsequent reporting periods are a full year.

Meaningful Use Standards and Measures

As required to achieve MU, eligible hospitals and EPs must report their performance on two types of measures:

- Performance Measures
- Clinical Quality Measures

The performance measures aim to improve quality, safety, efficiency and reduce health disparities. There are two types of performance measures: 1) Rate measures are numerically calculated with numerator and denominator data, 2) Attestation measures must be answered with a yes or no question.

Table 1: Summary Overview of Meaningful Use Core Set Measures

Short Name	Objective:	Measure:
Demographics	Record demographics: preferred language, gender, race and ethnicity, date of birth, and date of death and preliminary cause of death in the event of mortality in the eligible hospital or CAH.	More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have demographics recorded as structured data. (EPs, EHs & CAHs)

Short Name	Objective:	Measure:
Vital signs	Record and chart changes in the following vital signs: Height, weight and blood pressure and calculate and display body mass index (BMI) for ages 2 and over, plot and display growth charts for children 2-20 years, including BMI.	For more than 50% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23), height, weight, and blood pressure are recorded as structured data. (EPs, EHs & CAHs)
Problem List	Maintain up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data. (EPs, EHs & CAHs)
Medication List	Maintain active medication list.	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data. (EPs, EHs & CAHs)
Medication Allergy List	Maintain active medication allergy list.	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data. (EPs, EHs & CAHs)
Smoking Status	Record smoking status for patients age 13 or older.	More than 50% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have smoking status recorded as structured data. (EPs, EHs & CAHs)
Clinical Summaries	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days. (EPs Only)
Electronic Copy of Health Information	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures) upon request.	More than 50% of all patients seen by the EP or of the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days. (EPs, EHs & CAHs)

Short Name	Objective:	Measure:
ePrescribing	Generate and transmit permissible prescriptions electronically.	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology. <i>(EPs Only)</i>
CPOE Medication	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 30% of all unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE. NOTE: In Stage 2, the measure target increases to 60%. <i>(EPs, EHs & CAHs)</i>
Drug-Drug & Drug-Allergy Checks	Implement drug-drug and drug-allergy interaction checks.	Functionality is enabled for these checks for the entire reporting period. <i>(EPs, EHs & CAHs)</i>
Clinical Decision Support	For EPs, implement one clinical decision support rule relevant to specialty or high clinical priority. For eligible hospital or CAH implement one related to a high priority hospital condition along with the ability to track compliance with that rule.	Implement one clinical decision support rule. <i>(EPs, EHs & CAHs)</i>
Privacy/Security	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) of the certified EHR technology, and implement security updates and correct identified security deficiencies as part of its risk management process. <i>(EPs, EHs & CAHs)</i>
CQM	Report ambulatory and hospital clinical quality measures to CMS or, in the case of Medicaid, to the States.	Successfully report to CMS (or, in the case of Medicaid, to the States) ambulatory and hospital clinical quality measures selected by CMS in the manner specified by . <i>(EPs, EHs & CAHs)</i>
Exchange of Key Clinical Information	Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient's authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information. <i>(EPs, EHs & CAHs)</i>

Short Name	Objective:	Measure:
Electronic Copy of Discharge Instructions	Provide patients with an electronic copy of their discharge instructions at the time of discharge, upon request.	More than 50% of all patients who are discharged from an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it. <i>(Hospitals Only)</i>

Table 2: Summary Overview of Menu Set Meaningful Use Measures

Short Name	Objective:	Measure:
Drug-Formulary Checks	Implement drug formulary checks.	The EP, eligible hospital/CAH has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period. <i>(EPs, EHs & CAHs)</i>
Lab Results into EHR	Incorporate clinical laboratory test results in EHRs as structured data.	More than 40% of all clinical lab test results ordered by an EP or authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency departments (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data. <i>(EPs, EHs & CAHs)</i>
Patient List	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition. <i>(EPs, EHs & CAHs)</i>
Patient-Specific Education	Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate.	More than 10% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient-specific education resources. <i>(EPs, EHs & CAHs)</i>

Short Name	Objective:	Measure:
Medication Reconciliation	The EP, EH or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23). <i>EPs, EHs & CAHs</i>
Summary of Care	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral.	The EP, EH or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals. <i>(EPs, EHs & CAHs)</i>
Advance Directives	Record advance directives for patients 65 years old or older.	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded as structured data. <i>(Hospitals Only)</i>
*Immunization Registries	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow-up submission if the test is successful (unless none of the immunization registries to which the EP, EH or CAH submits such information have the capacity to receive the information electronically.) <i>(EPs, EHs & CAHs)</i>
Patient Reminders	Send reminders to patients per patient preference for preventive/follow-up care.	More than 20% of all unique patients 65 years old or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period. <i>(EPs Only)</i>

Short Name	Objective:	Measure:
Timely Electronic Access to Health Information	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four (4) business days of the information being available to the EP.	At least 10% of all unique patients seen by the EP are provided timely (available to the patient within four (4) business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information. (<i>EPs Only</i>)
*Submit Lab Results to Public Health Agencies	Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically.) (<i>Hospitals Only</i>)
*Syndromic Surveillance	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.	Perform at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which EP, EH or CAH submits such information have the capacity to receive the information electronically.). (<i>EPs, EHs & CAHs</i>)
* All EPs, EHs and CAHs must choose at least one of these populations and public health measures to demonstrate as part of the menu sets.		

Learning Objectives

This intense hands-on activity provides guidance to Indian Health Service (IHS) healthcare providers seeking to demonstrate MU of certified EHR technology in an individual provider environment. At the end of this session, participants will be able to:

- Use CPOE for medication orders directly entered by any licensed healthcare professional authorized to enter orders into the medical record per state, local, and professional guidelines.

- Implement drug-drug and drug-allergy checks
- Generate and transmit permissible prescriptions electronically
- Record patient demographics; preferred language, sex, race, ethnicity, date of birth
- Maintain an up-to-date problem list of current and active diagnoses
- Maintain an active medication list
- Maintain an active medication allergy list
- Record and chart changes in the following vital signs: Height, weight, and blood pressure and calculate and display body mass index (BMI) for ages 2 and older, plot and display growth charts for children 2-20 years, including BMI
- Record smoking status for patients 13 years or older
- Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule
- Provide patients with an electronic copy of their health information upon request
- Provide patients with an electronic copy of the discharge instructions upon request
- Report ambulatory and hospital clinical quality measures to CMS (or for Medicaid incentive payment, to the States)
- Provide clinical summaries for patients for each office visit
- Electronically exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patients authorized entities electronically
- Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.
- Implement drug-formulary checks
- Record advance directives for patients 65 years old and older
- Incorporate clinical lab-test results into certified EHR technology as structured data
- Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach
- Send reminders to patients per patient preference for preventative/follow-up care
- Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP

- Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate
- Perform medication reconciliation
- Provide a summary of care record
- Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice
- Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submissions in accordance with applicable law and practice.
- Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice

Meaningful Use Stage 1

2013 Summary of Changes

Reporting Requirements

- EPs must complete:
 - 13 Core Objectives
 - 5 Objectives out of 10 from Menu Set
 - 6 Total Clinical Quality Measures (3 core or alternate core, and 3 out of 38 from additional set)
- EHs & CAHs must complete:
 - 12 Core Objectives
 - 5 Objectives out of 10 from Menu Set
 - 15 Clinical Quality Measures

Eligibility Requirements

- **Patient Volume Determination and Encounter Definition**
 - Option to determine volume based on a 90-day period in the previous calendar year OR a 90-day period in the previous 12 months preceding the date of application (***CMS has allowed state flexibility on the look back period for 2013.***)
 - Medicaid encounters are now defined as any services rendered on any one day to an individual enrolled in an eligible Medicaid program (***encounters no longer have to be paid to be counted.***)
- **Hospital Medicaid Incentive Calculation**
 - Hospitals beginning participation in 2013 and later may now use the most recent continuous 12-month period for which data are available prior to the payment year.

Stage 1 MU Measures and Exclusions

- **CPOE- Measure change**
 - More than 30 percent of medication orders created by the EP or authorized providers in an inpatient or emergency department of an EH or CAH (POS 21 or 23) during the EHR reporting period are recorded using CPOE (***based on the total number of medication orders created during the EHR reporting period.***)
- **E-Prescribing – New Exclusion added**
 - EPs can exclude from this measure if the EP does not have a pharmacy within his/her organization and no pharmacies accept electronic prescriptions within 10 miles of the EP's practice location at the start of the EHR reporting period.
- **No Longer Required to Report**
 - The Electronic Exchange of Key Clinical Information has been removed.
 - Reporting Clinical Quality Measures is ***no longer a separate objective for ambulatory of hospitals; however, EPs, EHs, and CAHs are still required to report on clinical quality measures in order to achieve meaningful use.***

Note that these changes are effective as of October 1, 2012, for Eligible Hospitals (EHs) and Critical Access Hospitals (CAHs) and as of January 1, 2013, for Eligible Professionals (EPs). These updates are only applicable for program year 2013 and are not retroactive to program year 2012 applications submitted during the EHR reporting period.

Instructors and Facilitators

- David Taylor, MHS, RPh, PA-C, RN, Indian Health Service (IHS) Office of Information Technology (OIT) EHR Deployment Manager
- Phil Taylor BA, RN, (Contractor), Clinical Application Specialist, Medsphere Systems Corporation
- JoAnne Hawkins (Contractor), Meaningful Use Senior Analyst, Data Networks Corporation (DNC)
- Kimiko Gosney, MS, CC(NRCC), Alaska Native Tribal Health Consortium (ANTHC) Clinical Applications Coordinator
- Karen Sidell, Alaska Native Tribal Health Consortium (ANTHC) Meaningful Use Consultant
- Scott Dufour, Alaska Native Tribal Health Consortium (ANTHC), ATHS RPMS Support

Detailed Agenda
All times are Alaska Time!

Monday		
Start	Topic	
8:30	Welcome and Introductions All At the end of this session participants should be able to: <ul style="list-style-type: none"> • Identify participant needs and expectations (ThinkTank®) • Review agenda and learning objectives 	
9:00	NIHB/ANTHC Regional Extension Center & USET Consultant Services Rich Hall At the end of this session, participants should be able to: <ul style="list-style-type: none"> • Review NIHB activities • Define roles and responsibilities of NIHB, USET, OIT EHR Deployment and MU/IPC Consultants 	
9:15	Meaningful Use and the Certified EHR: Requirements, Audit Documentation, Q&A Karen Sidell At the end of this session, participants should be able to: <ul style="list-style-type: none"> • Review Meaningful Use requirements • Understand and be able to produce MU Audit documentation 	
11:00	Running Meaningful Use Reports Karen Sidell At the end of this session, participants should be able to: <ul style="list-style-type: none"> • Run and interpret Meaningful Use reports for individual EPs and groups of EPs 	
12:00	Lunch	
1:00	Meaningful Use: Performance Measures and Clinical Quality Measures Kimi Gosney & Karen Sidell At the end of this session, participants should be able to: <ul style="list-style-type: none"> • Understand and select performance measures (core and menu set) for SEARHC clinics • Understand and select clinical quality measures (core and menu set) for SEARHC clinics 	
4:00	Wrap-up and Next Steps	

Tuesday		
Start	Topic	
8:30	<p>Review of RPMS EHR for Meaningful Use: iCare MU Reports, iCare Clinical Reports, Scavenger Hunt</p> <p>Kimiko Gosney & Scott Dufour</p> <p>At the end of this session, participants should be able to:</p> <ul style="list-style-type: none"> • Understand where MU data elements are stored in the RPMS database • Understand how to run iCare MU reports 	
10:00	<p>MU Measures met by attestation</p> <p>Kimiko Gosney & Karen Sidell</p> <p>At the end of this session, participants should be able to know how to answer MU report questions regarding the following measures met by attestation:</p> <ul style="list-style-type: none"> • Clinical Decision Support • Protect Electronic Health Information (IT, HR, etc) • Patient Lists • Patient Electronic Access • Immunization Registry data submission (VacTrAK) • Syndromic Surveillance data submission (“Influenza-Like Illness” or ILI) 	
11:15	<p>MU Measures generated by Registration (Demographics)</p> <p>Kimiko Gosney & Karen Sidell</p> <p>At the end of this session, participants should understand the following MU measures, how they are captured, and by whom:</p> <ul style="list-style-type: none"> • Preferred Language • Sex • Race • Ethnicity • Date of Birth 	
11:30	<p>MU Measures generated by Medical Records</p> <p>Phil Taylor</p> <p>At the end of this session, participants should understand the following MU measures, how they are captured, and by whom:</p> <ul style="list-style-type: none"> • Electronic Copy of Health Information 	
12:00	Lunch	

Tuesday		
Start	Topic	
1:00	<p>MU Performance Measures generated by clinical care staff</p> <p>Kimiko Gosney & Karen Sidell</p> <p>At the end of this session, participants should understand the following MU core and menu set measures, how they are captured, and by whom:</p> <ul style="list-style-type: none"> • Allergies (Core) • Vitals (Core) • Smoking (Core) • Medications (Core) • Problem List (Core) • Clinical Summary (Core) • Education (Menu) • Lab (Menu) • Medication Reconciliation (Menu) 	
3:00	<p>MU Menu Set measures and where they come from</p> <p>Kimiko Gosney & Karen Sidell</p> <p>At the end of this session, participants should understand the following MU menu set measures, how they are captured, and by whom:</p> <ul style="list-style-type: none"> • Reminders (Menu) • Transitions of Care (Menu) 	
4:30	<p>Wrap-up and Next Steps</p> <p>All</p>	

Wednesday		
Start	Topic	
8:30	Review Previous Days Training All	
9:00	Followup on SEARHC issues from Mt. Edgecumbe Hospital EHR go-live June 3 David Taylor & Phil Taylor <ul style="list-style-type: none"> • Resources Tab – web pages not displaying scroll bars • Cover sheet “flicker” issue • Launch BH GUI from EHR • Adding additional signers for notes on telephone calls to patients at other divisions (ref Susan Hennon/Nutrition issue 7/3/13) • Coding queue <ul style="list-style-type: none"> • Staff members from different divisions are showing up in the coding queue for patient encounters they were never part of • Pharmacy visits & visit relinker? • Templates • Reminders – can we start thinking about this? ---to be continued on Thursday 0830--- 	
12:00	Lunch	
1:00	Prenatal Care Module David Taylor, Phil Taylor & Kathy Ray <ul style="list-style-type: none"> • Configure the Prenatal Care Module • Prenatal Care Module training 	
5:00	Adjourn	

Thursday		
Start	Topic	
8:30	Continuation of SEARHC issues from previous morning David Taylor & Phil Taylor <ul style="list-style-type: none"> • • 	
12:00	Lunch	
1:00	Continuation of SEARHC issues from Thursday morning as needed David Taylor & Phil Taylor <ul style="list-style-type: none"> • • 	
4:30	Adjourn	

Biographical Sketches

CAPT (ret) David R. Taylor, MHS, RPh, PA-C, RN, NCPS

EHR Training and Deployment Manager

IHS Office of Information Technology

CAPT (ret) David Taylor is a retired Commissioned Officer in the United States Public Health Service and is a certified physician assistant, registered pharmacist, and registered nurse. Captain (ret) Taylor holds more than 33 years of public health, clinical, and clinic-administrative experience in the Indian Health Service (IHS). During his commission, he has served as a pharmacist, physician assistant, quality manager, risk manager, and compliance officer for the Pine Ridge, South Dakota and Cherokee, North Carolina Indian Hospitals. He has also served as an HIV/AIDS/STD consultant, performance improvement consultant, pharmacy consultant, and diabetes clinical consultant for the Nashville Area Indian Health Service. At this time, he is the EHR Deployment Manager for the IHS Office of Information Technology and has been charged with both training and deployment of the Electronic Health Record throughout the entire Indian Health Care system. David Taylor has been awarded the PHS Meritorious Service Medal (MSM) in recognition for his accomplishments in the EHR arena.

Phil Taylor

Phil...

JoAnne Hawkins

Currently serves as a contractor with Data Network Corporations. JoAnne is the Team Lead for 15 Meaningful Use Field Consultants. She has over 13 years of training experience in various industries including healthcare. Her focus is to help Indian Country achieve Meaningful Use.

Karen Sidell

Karen...

Scott Dufour

Scott...

Kimiko Gosney

Kimiko...

Kathy Ray, CNM, CAC, FATA

Kathy has been a Clinical Applications Coordinator at Parker IHS, Parker, AZ, since October 2005. She has the additional duties of being the MU Coordinator; a member of the IPC3 team; and, the GovTrip FATA for the Colorado River Service Units. She has also served as the Chair of CIMTAC - Clinician's Information Management Technology Advisory Council. Prior to moving to Parker, Kathy had been with the Rosebud Sioux on the Rosebud Indian Reservation in South Dakota as a permanent employee since 1994. Kathy has worked with the Women's Health Package since 1996 – when it was first released. She is currently the Federal Lead for the Women's Health Package and iCare. She enjoys working with various RPMS packages and EHR, and training others on how to use them.

Appendix A: EHR v1.1 Patch 8 Dependencies

EHR v1.1 patch 6

- APSP patch 1008

EHR v1.1 patch 7

- APSP patch 1009
- USR Patch 1002 and 1003
- TIU patch 1007

EHR v1.1 patch 8

- TIU patch 1008
- APSP 1010
- Cimmaron – Lab patch 1027
- Vangent Registration patches 7 and 8
- Cimmaron – BJPC patch 5
- Cimmaron – BJPC patch 6
- Vangent – C32 patch
- Vangent eRX build
- GMRA*4.0*1001
- GMRA*4.0*1002
- GTMS patch 1004
- Cimmaron – APCH patch

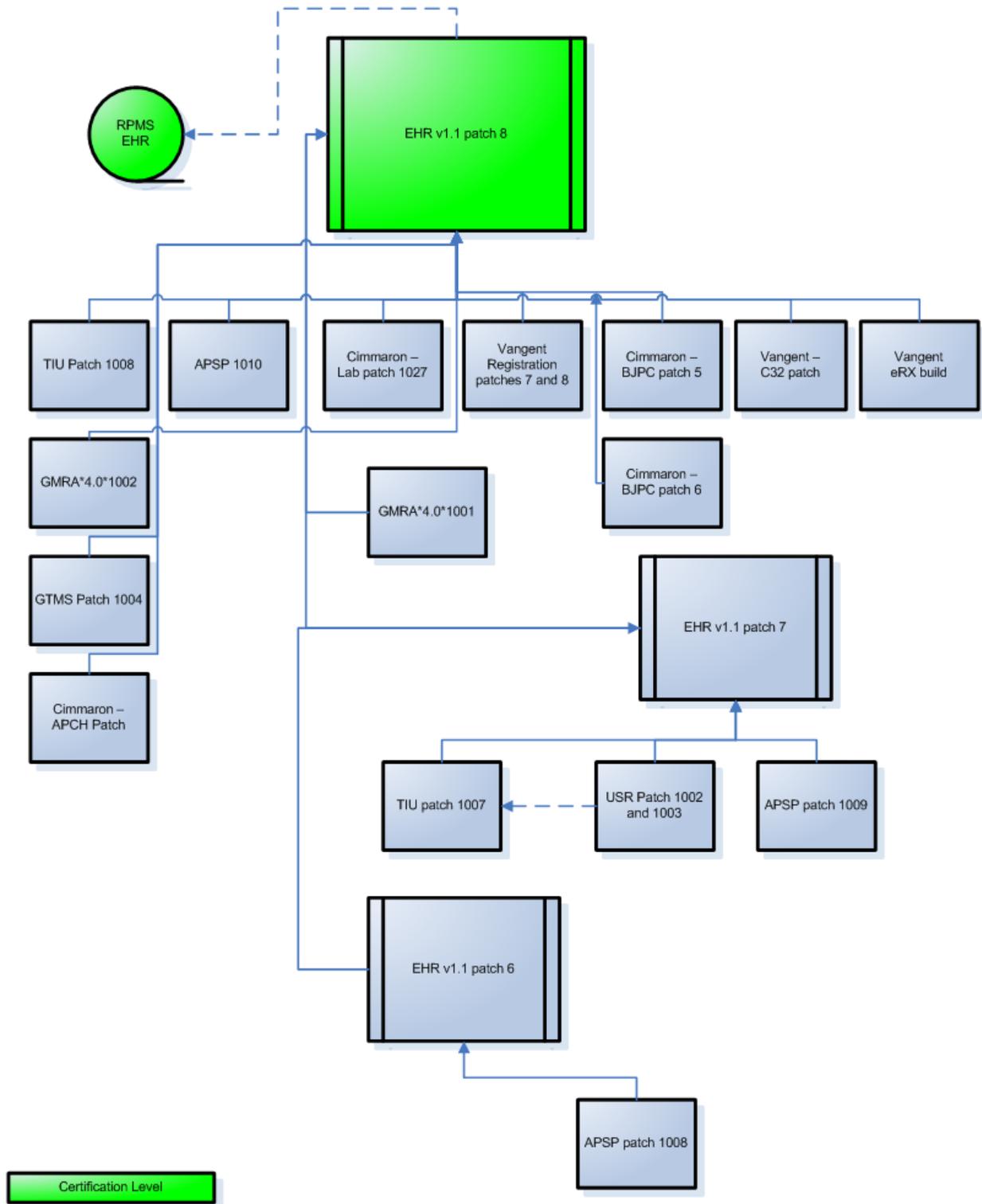


Figure 1: Patch Dependencies Diagram current as of February 2011