# Pre-Implementation Questions and Answers

# V1.3

**December 8, 2021**

# Contents

# 1. EMR Basics

## 1.1 What is a Shared Health Record?

The Electronic Medical Record (EMR) is a single province-wide solution that modernizes how we collect, share and use patient information.

The EMR is an important component of the overall Electronic Health Record as Primary Care provides a significant portion of a patient's medical history. By combining local information - like visit history and clinician notes - with other information from across the EHR such as diagnostic imaging and lab results, a more comprehensive patient record will be available to providers across the continuum of care.

Provincial access and sharing of patient information represents a fundamental shift from a clinic's patient chart to a patient's shared electronic record containing encounter information from across care settings (e.g., clinical notes from Specialists or other providers that the patient visited).

A key difference between a stand-alone EMR used in most parts of the country and a provincial EMR is:

- All users are contributing to a patients' electronic chart.
- With collective access to viewing and sharing patient information each provider has a more comprehensive view to that patient to support their role in providing care.
- It supports, promotes and enables team-based care – no matter where your practice is located in the province.

Within the EMR, it is possible to filter for encounter information specific to your practice and to mark certain sensitive information as confidential – requiring other authorized providers to provide valid reasons for accessing the information.

## 1.2 Will all integration points be available for implementation?

The following integrations are now live:

- Clinical Documents (CIS)
- Diagnostic Imaging Reports (DI)
- Demographics and Medicare Eligibility (CR)

Laboratory Results integration will be delivered in 2 implementation phases late 2021 to early 2022.

PrescribeIT is anticipated to be integrated later in 2022.

In the future, other integration points may be considered.

## 1.3 What functionality will be available for implementation?

Core EMR functionality is available for rollout in 2021. Examples include:

- Patient Demographics (including integration with the provincial Client Registry for demographic information)
- Encounter Documentation
- eReferrals
- E-faxing (e.g., for laboratory or diagnostic imaging requisitions, eReferrals, prescriptions prior to PrescribeIT integration, etc.)
- Automated Billing (including integration with the Integrated Claims System)
- Data Analytics

The EMR Program is still planning for the roll-out of the more advanced functions such as the Patient Portal and the Video Conferencing Virtual Visits.

## 1.4 Can a clinic decide what functionality it wants to implement?

The standardization of functionality within the provincial-wide solution is key to achieving the One Person, One Record vision. There will be a single instance of a patient record.

It is expected that all core EMR functionality (see section 1.3) will be used as of initial Go Live. Pertaining to the Patient Portal and other advanced use functions, we will support clinics to learn at a pace that is manageable for their practice. While the goal is to utilize all solution capabilities, it will be an evolution.

## 1.5 Who will use the EMR?

The initial roll-out of the EMR is for use by family physicians, community-based specialists, nurse practitioners and support staff. The EMR Program has evaluated unique situations whereby other providers have been included.

In future phases, other areas such as Walk in Clinics, Public Health Nursing, Mental Health and Addiction will be considered. Providers requiring View Only access may also be considered (e.g., Emergency Department physicians).

## 1.6 Will the use of the EMR increase my workload?

There will be a learning curve associated with implementing a new solution. The time it will take to become more efficient at navigating, entering information, and adapting to a new workflow will depend on the user role, their comfort with technology in general, and the ease at which they can adapt to a transformation in the way patient care is delivered. For some, it may take days or weeks, for others several months.

It is recommended that clinics reduce patient capacity to 50% for go live and at least the first week or two, then consider ramping up incrementally.

Evidence gathered from the >85% of clinicians who have implemented an EMR in Canada indicates that overall practice management functions including scheduling, billing, exchanging clinical information with hospitals, labs and pharmacies will require significantly less effort than if using paper records or an EMR

that is not integrated with these other points of care. These time savings may offset – at least in part – the time required to learn and use the new solution.

### 1.7 Can clinicians add their own forms?

Customized forms cannot be added, however, during your practice implementation, the EMR Program will assess the forms used within your clinic to determine if there are opportunities to further standardize provincially. There are more than 130 provincially standardized forms being developed. There is a formal process for requesting new or modified form through the EMR Program.

### 1.8 Will clinical notes be merged with those of other providers that the patient has seen?

Clinical notes from all providers within the community-based environment would be added to a single patient chart as part of the One Person, One Record approach. When migrating clinical data from different sources, no clinical information will be overridden.

## 2. Preparing for the EMR in your practice

### 2.1 Is implementation of the EMR mandatory?

The more widely used, the more benefits to patients and the broader population. We are putting many supports in place to facilitate this transition – including financial assistance and extensive implementation support offerings. We are encouraging everyone make the transition prior by the fall of 2022 to not only take advantage of the funding, which does have a shelf life, but to make this move to support increased patient safety, better management of chronic disease, and improved population health for all Islanders.

### 2.2 How are clinic implementations being scheduled?

We know many physicians have waited a long time for the opportunity to adopt an EMR. The EMR Program is putting in place timelines to have the majority of the providers using the solution by the fall of 2022.

To achieve this, we foresee implementing multiple sites in parallel.

This will require strategic use of our EMR Program resources to ensure we have the right teams on the ground at the right time.

Some example factors that may impact the scheduling:

- Size of your clinics
- Data migration capabilities
    - ICORE, Oscar & QHR
    - Practimax
    - MedAccess

- Alignment with Primary Care Strategy changes
- Site readiness
- Specialist requirements for custom configurations

Once you have enrolled, we will continue to update you on the scheduling plans to ensure you have enough lead time to prepare.

## 2.3 What agreements do I need to sign to enroll?

All Fee for Service providers will be required to sign a participation agreement before we begin the implementation process. The scope of the agreement includes:

Eligibility Criteria

- Fees
- Term and Termination
- Implementation and Use of EMR
- Custodians and Information Manager
- Sharing of EMR Data
- Privacy and Security Obligations
- Retention and Disposition of Information
- Breach Protocol
- Auditing

The overall EMR enrollment process includes steps for registration for PrescribeIT®. It will become an essential component of the EMR solution and bring us collectively closer to the ***One Person, One Record*** vision. PrescribeIT® is the more secure alternative that allows prescriptions to be *digitally* sent from a prescriber to a patient's pharmacy of choice.

## 2.4 What is the role of the Clinic Lead?

The role of the Clinic Lead is to guide the implementation activities similar to a Project Manager. This is often a clinic manager or provider, medical office assistant, nurse, etc. who is familiar with your clinical workflows and willing to play an active role in the deployment of the CHR. Key responsibilities:

- Vital to a successful implementation
- Regular communications with clinic providers and staff to keep them abreast of progress and when their participation is required
- Coordinate of activities on the clinic side
- Ensure tasks are completed on time
- Liaison between the clinic and the Telus/EMR Program team.

## 2.5 Is there a Telus CHR Sandbox for providers?

As part of the implementation process, a Telus CHR sandbox will be made available for your staff. In the meantime, providers are invited to watch the recorded demonstration available on the EMR program website.

## 2.6 Will I need to migrate all of my existing patient charts?

For most EMR implementations it is not common practice to input all patient data from current paper form to the EMR. There is no requirement to scan all existing paper records.

*Webinar 3 – Preparing for the Transition* focused on data preparation and migration activities. A recording is available on demand on the EMR Program website.

Best practice recommends, at the minimum, that the following Cumulative Patient Profile (CPP) information be captured for all frequent patients and those with chronic disease:

- Problem lists
- Past medical history
- Medication profile
- Allergies
- Social history (e.g., smoking, alcohol use)
- Family history (for cancer screening reminders/alerts)
- Surgical history
- Reminders about the patient
- Private health insurance coverage

You and your staff may wish to go through all patient charts and ensure this information is currently captured and up to date.

Depending on how much information you want to enter, you could estimate approx. 8 minutes per chart.

The following supports are available:

- Data Entry Support
    - MSPEI will reimburse physicians up to a max. to pay their support staff extra for the data entry support. (Must be trained on the EMR), or;
    - EMR Program will provide you with a data entry person to provide you with up to 30 hours of data entry support
- MSPEI and Health PEI are planning to introduce a stipend or fee code to also remunerate the extra effort required to validate patient data in the EMR

## 2.7 How long will data migration take?

The timeline for data migration will vary based on clinic size, extent to which the data is prepared for migration (e.g., Cumulative Patient Profile up to date, tasks closed, etc.), scope of existing EMR data, etc. Preparing the extract from the existing EMR, migrating data, validating and testing could take from 8-12 weeks of elapsed time with potentially 12-16 hours required on the part of clinic staff.

Watch *webinar 3 – Preparing for the Transition* for more details.

## 2.8 Who participates in data migration activities?

The EMR Program and Telus will work with you to develop your data migration plan and guide you through the process.

Data entry activities would be undertaken by the clinic.

Data migration would be undertaken by Telus, with validation performed by the clinic and your EMR Advisor(s).

Data migration is a critical step in the implementation process. Clinics should anticipate effort and availability of required staff to validate data.

## 2.9 Can we expect to need a dual paper and electronic environment for a period of time?

Given the recommendation is start fresh for paper practices (i.e., not scan and enter *all* historical patient data apart from the core elements of the Cumulative Patient Profile), you will likely need to refer to historical information in the paper charts for a period of time. However, continuing to update paper charts is not recommended.

## 2.10 Will the Client Registry be the source of truth for client demographic data migration?

Client Registry is the source of truth for the *basic* demographic elements (i.e., Name, Gender, Date of Birth, Mailing Address, Home Address, Medicare Eligibility, and Date of Death from Vital Stats). We understand that the majority of the information in the client registry has recently been updated as it was used for the COVID-19 vaccinations.

This means that the CR will ***overwrite*** patient demographic basic elements (as above) for all matched patients in the EMR. Matching is based on Health Card Number, Gender, Date of Birth.

The first time a patient is created from the CR, Phone numbers (i.e., Home Phone, Cell Phone, Business Phone) will be populated in the EMR. From that point forward, the EMR becomes the source of truth for Phone numbers. When updated demographics are sent to the CR, they will update Phone numbers from the EMR.

All other demographic elements including Preferred Name and email address that are not part of the *basic* ones listed above will not be overwritten by the CR.

For more information, please refer to the Client Demographic Support Materials on the EMR Program Website: EMR User Resources | Government of Prince Edward Island

### 2.11 Will patient communication materials be provided to clinics to share with their patients?

Yes. The EMR Program will prepare standard patient messaging for clinic's to leverage and, if required, any consent related forms.

## 3. Costs

### 3.1 When is funding received?

Half of the grant will be provided when your clinic has been scheduled; the remaining will be provided after implementation. You are required to sign you participation agreement before the first half of the grant is released.

### 3.2 Why is the Province not fully funding licenses?

The province is making an $8.4 investment into this program. It also recognizes that supporting physicians with implementation costs is important. We are fortunate to have limited-timed funding from Infoway. With that funding and the Government investment, all physicians eligible for an EMR will have their license covered until April 1, 2023. Salaried provider licensing costs will be covered ongoing as part of overhead. For Fee for Service providers, licensing will be subsidized 50% from April 1, 2023 – 2024 and 30% from April 1, 2024 forward. A cross-country review of other subsidized physician EMR programs, illustrates that the PEI program is very competitive.

### 3.3 Will a shared practice need to pay double the provider yearly fees?

The yearly fees apply to each provider rather than a practice.

### 3.4 How will funding work for clinicians who are both salaried and FFS?

They would be covered as per a salaried clinician and as such, will not receive additional funding.

### 3.5 Will data entry support be provided?

Through the MSPEI Data Entry Reimbursement Program, eligible providers can apply for reimbursement (up to $1000) to hire data entry support OR the EMR Program will provide you with a data entry person to provide you with up to 30 hours of data entry support.

### 3.6 How will in-hospital services be billed?

The billing will be done the same as it is currently with iCore or Practimax. All services can be billed from within the CHR (e.g., on call stipends, hospital visits, etc.).

## 3.7 Will I be compensated for lost revenue during my implementation?

The EMR program will work with you to establish an implementation and support plan that aims to minimize the disruption to patient care. The time for training will be covered and as the EMR Program refines the implementation approach, more opportunities for support will be considered. Other supports are described below.

The following financial supports are offered to physicians:

**Implementation Grant | $8,000 - $6,000**
Fee for service physicians who enrolled to adopt an EMR by May 1st or Sept 1st will receive a $8,000 or $6,000 grant to support the costs that may be incurred with EMR implementation such as new hardware purchases. 50% of the grant will be released after you sign your Participation Agreement. The second half will be provided within a month following you going live with the EMR.

**Licensing, Training and Implementation Costs | $7,500/physician**
All costs associated with training and implementation are covered by the EMR program. In addition, the government will be covering the EMR licensing fees up until 2023. After 2023, licencing fees will be cost-shared with fee-for-service physicians. Salary physicians will continue to have their licencing fees covered by Health PEI:

- -- $1500 Provider | $1500 Government
- 2024-2025 -- $2100 Provider | $900 Government

**Training Days – _Admin Fee Code Billing | $3,000/physician**
Physicians are asked bill/shadow bill the Administration fee code **0050** for the 7.5 hours for each training day (up to two training days). Note: To bill through the new EMR the max billing for meetings is $600/day. Click the override calculations check box and put in the appropriate fee amount which is $1500/day. Add a comment stating it is for EMR training.

**Data Entry Reimbursement Program | $1,000/physician**
MSPEI members scheduled to implement an EMR may apply for an up to $1,000 fund to support hiring a data entry support person to enter patient records into the EMR.

Link: https://www.mspei.org/emr/#emr-data

**Compensation for First Patient Encounters with an EMR**
It is also recognized that with the new EMR, there is a learning curve and extra time is required with each patient the first time they are seen with the EMR. This allows time to validate patient's information within the EMR and familiarize yourself and the patient with the EMR. MSPEI and Health PEI are working together to explore what funding may be available in the Master Agreement to recognize this additional EMR effort. Once a recommendation is made, it will be retroactive to those who have already adopted an EMR.

## 3.8 What happens after the project funding is gone?

The EMR Program is pleased to have been able to secure funding to support physician implementation costs up until the fall of 2022. We strongly encourage physicians to initiate the implementation process before this time to take advantage of that funding. As of today, we have not secured funding to support the implementation costs after this window.

However, the EMR Program will continue to provide services to support clinical and administrative advanced use of the CHR over the years to come.

### 3.9 When can my practice expect to see a return on investment?

Although it will vary based on the extent to which the advanced functions of the EMR are used, Pan-Canadian research shows an average return on investment within 18-month of EMR deployment.

## 4. Privacy and Security

### 4.1 How can I ensure that my EMR and clinic information is secure?

Details pertaining to the privacy and security of patient information will be covered as part of the Privacy and Security Training.

A Privacy Impact Assessment and Threat Risk Assessment was completed to determine the privacy and security mechanism required to ensure the protection of patient personal health information in compliance with the Health Information Act and other applicable legislation.

### 4.2 Will we still need to access the CIS through a Virtual Private Network?

Clinical documents, laboratory results and diagnostic reports will be visible from with the CHR. For access to other functions within the CIS (e.g., PACS images, etc.), current access processes will apply.

### 4.3 Is the Cloud in Canada?

Yes.

### 4.4 Will data be mined from the EMR? If so, for what purpose(s)?

One of the major benefits of having one solution provincewide is that we will have access to richer and more comprehensive data to support evidence-based decision making for population health and the health-care system. As decisions are made on how to use this data to the fullest potential, more information will be shared. The EMR Program Governance will provide oversight and decisions regarding what information will be shared with whom, for what purpose – in accordance with relevant privacy legislation and directives.

## 5. Access to the System

### 5.1 Can I enter information into my EMR remotely?

Yes. You can access and perform functions in the EMR from anywhere you have access to a secure internet connection – from the clinic or on the go.

Access will not be restricted to government devices.

## 5.2 Who will have access to my patient's medical records?

The provincial-wide solution represents a single instance of a patient record – accessible to community-based providers within the patient's circle of care.

As per the College of Physicians and Surgeons' guidelines for Transfer/Sharing of Clinical Information, access to a patient's medical records should be limited to Health Professionals or institutions to the extent necessary to provide proper medical care. That is, for the use of the information on a 'Need to Know Basis'. This can be managed through role-based access (i.e., only those who require access will be granted it). An override function enables a clinician to access patient data in another clinician's roster.

Mental health or sexual health notes in a patient's primary care record that are to be kept anonymous can be marked as confidential. These will require an additional level of security to access.

Access to patient records is regularly audited.

## 5.3 Can I use a MacIntosh Computer to access the CHR?

Yes.

## 5.4 Can a Clinician use more than one device to access the CHR at the same time?

Yes.