SECTION		GOVERNING POLICY	
7.00 Information Systems (IS)		01 IS Infrastructure, Strategy and Management	
SUBJECT			
03 Electronic Medical Record (EMR) Management			
EFFECTIVE DATE:	03/01/2014	**REVIEWED/REVISED:**	10/15/2014

7.01.03 ELECTRONIC MEDICAL RECORD (EMR) MANAGEMENT

PURPOSE: The purpose of this operating procedure is to establish a management process for the electronic medical record that defines access and permissions, system integrity and record completeness standards, training and technical assistance efforts, system change control process, and communication plans.

Management of the EMR requires decision-making, planning and quality improvement throughout its life cycle. The EMR is a mission-critical function that supports the provision of care across the entire provider network system. As a result, procedures must be in place to support the integrity and accuracy of the information and components in order to achieve the highest effectiveness from the product. It is also imperative that users of the product follow strict access, confidentiality and security practices to provide for acceptable use and security of the protected health information maintained by the system.

SYSTEM COMPATIBILITY

The LEO system is hosted, developed and maintained by PCE Systems. The LEO applicable is available in three environments: 1) production, 2) training, and 3) development. The production environment is the live setting that users use for electronic health record documentation. The training environment is a duplicate of production to use for training purposes; changes within training will not harm the production system. The development environment is used to create and test new system changes before they are moved to production.

Internet Explorer: The LEO application is programmed to be compatible with Internet Explorer (IE). There are specific functions and forms that are not fully operable unless used in Internet Explorer. Therefore, the agency requires that Internet Explorer is used as the web browser to run the LEO system. The most recent version of Internet Explorer should always be used, as PCE Systems works diligently to maintain compatibility with the newest IE release.

Adobe Reader: The LEO application is programmed to use Adobe Reader most recent version to be fully operational when viewing and printing PDF documents within the LEO systems.

Java Installation: The LEO application must have the most recent JAVA update installed on your computer/hardware to be compatible with viewing certain documents within LEO, scanning/uploading documents and capturing signatures with the compatible signature pads. This software must be installed prior to installing any hardware (Scanner/Signature pad).

ACCESS AND PERMISSIONS

Expected Use: LifeWays staff and contracted service providers are expected to fully implement the LEO system within their workflow to document services rendered. Staff of programs or providers that are authorized to serve a LifeWays consumer is expected to document care using all appropriate modules

SECTION		GOVERNING POLICY	
7.00 Information Systems (IS)		01 IS Infrastructure, Strategy and Management	
SUBJECT			
03 Electronic Medical Record (EMR) Management			
EFFECTIVE DATE:	03/01/2014	**REVIEWED/REVISED:**	10/15/2014

and forms that have been made available and within their scope of care. This requirement is to ensure complete and accurate service documentation and facilitate effective care coordination amongst mutually serving program and providers within the LifeWays CMH system. There are no exclusions to the requirement to use the LEO system unless a user can demonstrate that it creates a significant hardship and this has been reported to and approved by the Director of Quality Improvement & Technology Services.

User Setup: The agency is responsible for the oversight and establishment of access levels and permissions within the EMR system. The LifeWays Information Systems Specialist is responsible for user setup, granting permissions and ongoing monitoring to ensure security and privacy is upheld. User setup shall be a centralized role within the agency that is managed by the IT team.

Provider Administrator: LifeWays may choose to delegate the setup and management of provider staff users to a designated and trained Provider Administrator at each provider agency. This is considered a privileged function; high ethical standards and security practices must be applied within this role. These permissions can be removed at any time by the agency. The Provider Administrator must follow the user setup manual provided by LifeWays. The Provider Administrator is expected to strictly adhere to LifeWays guidelines regarding creation and management of functional access and privileges for users. LifeWays shall monitor the Provider Administrators user setup audit trails and the integrity of their managed users to ensure security and privacy is upheld within user access levels. LifeWays reserves the right to modify user setup at any time if it is determined to be inappropriate. Non-compliance with the expectations as a Provider Administrator will result in revoke privileges and possible corrective action.

All system users are responsible for maintaining secure practices, including:

1. Privacy of **passwords**;
2. Maintaining **physical control** of the equipment that is used to access the EMR; and
3. Following the **minimum-necessary rule** for accessing and disclosing protected health information.

Secure Passwords: Passwords security is critical to the protection of information in the EMR. Users have a primary role to minimize the risk of improper disclosure by using the following required secure password practices.

1. Keep password secure and confidential to all others.
2. Create strong passwords using alpha, numeric and special characters.
3. Change the password completely when prompted by the system or if security has been compromised.
4. Lock the computer workstation when stepping away from your device every time. This can be done by using Ctrl-Alt-Delete and then selecting “Lock this Computer.”
5. Do not share password with others
6. Do not write down the password.
7. Do not allow others to log in as you.
8. Do not allow other people to watch you key your password in.

SECTION		GOVERNING POLICY	
7.00 Information Systems (IS)		01 IS Infrastructure, Strategy and Management	
SUBJECT			
03 Electronic Medical Record (EMR) Management			
EFFECTIVE DATE:	03/01/2014	**REVIEWED/REVISED:**	10/15/2014

9. Do not save your password in your internet browser.

Passwords are set to expire every 90 days in the EMR. If you forgot your password, you may use the link "Forgot My Password" on the login screen to reset it and obtain a temporary password. If you have been locked out due to many unsuccessful attempts, you will need to contact the IT help desk (517-780-3367) to obtain a reset.

Physical Controls: Users are responsible for maintaining the physical security of their workstation that is used to access the EMR and protected health information. This includes immediately locking the device when not in use, closing doors when away from the office where the device is located, placing devices out of site when traveling (e.g. truck of car), password-protecting the device for user authentication, and being aware of the immediate surroundings and risks.

Minimum-Necessary Rule: Users are created with very specific access to areas in the EMR based on their position and function. It is expected that the user access only the minimum information that is necessary to complete their job function. The actions carried out by users in the EMR are logged and recorded. This includes all attempts to read, write and delete data. LifeWays reserves the right to review the audit trails to determine if the access level is necessary and appropriate. Audit trail reports are available to LifeWays System Administrators on the IT team.

The agency retains the right to terminate any user access at any time.

ACCESS TO CASE RECORDS

Users are granted access to case records in LEO based on their affiliation with a service location. LifeWays or the designated Provider Administrator is responsible for assigning the user to a location and grating functional access. Location assignments must be done with great care and caution. Users shall not be assigned to locations in which they are not employed. Once assigned to a specific location by LifeWays or the Provider Administrator, the user will have access to the consumer records that are also assigned to that location. Case records within the assigned location must be accessed on a need to know basis. Simply having access to the file does not grant the user rights to review protected health information.

Terminated Access: It is expected that users complete a discharge summary immediately when it is known that their organization/program will no longer serve the case; a discharge summary will close out the access level. The IT team may request a discharge summary from the provider to properly close from the case. LifeWays reserves the right to conduct an administrative closure of agencies or users to remove access to a case record when there is a period of inactivity. The purpose is to minimize case access to only users that are authorized for service delivery and are activity serving the case.

Once the case is closed, the provider and assigned staff will have limited view-only access to the case through LEO for a period of 90 days. The 90-day window after case closure is intended to provide the

user with limited access to the case in order to complete final claims submission and clinical documentation activities. After the 90-day period, the system will automatically restrict access to the record and the user is forbidden from accessing the consumer's electronic medical record.

INTEGRITY AND COMPLETENESS OF INFORMATION

EMR Standards: Professionals accessing the EMR shall consistently follow the standards established by the agency to achieve and maintain a high level of integrity and completeness of information within the EMR. The agency has established a detailed set of **Quality and Integrity Standards for Electronic Medical Records** (Attachment 1). Conformance to these standards is expected by all users.

Use of Electronic Forms: LifeWays has created electronic forms within the EMR for primary chart documents. These forms must be completed electronically within LEO and are no longer offered on paper. It is expected that users fully utilize the electronic forms as appropriate to their scope and practice. A scanned document of a paper form is unacceptable if an electronic form has been made available.

The following is a list of the standardized clinical forms that are required for providers and programs of LifeWays:

- Access Screening
- Crisis Intervention
- Clubhouse Progress Note, Weekly
- Death Report
- Discharge Summary
- Financial Determination
- Group Progress Note
- Incident Report
- Injection Dispense Note
- Intake/Update Assessment
- Integrated Health Assessment
- Medication Delivery Progress Note
- Medication Review
- Pre-Planning
- Progress Note
- Psychiatric Evaluation
- Residential Quality of Life Assessment (for services providing in a residential setting)
- Supported Employment Progress Note

SECTION		GOVERNING POLICY	
7.00 Information Systems (IS)		01 IS Infrastructure, Strategy and Management	
SUBJECT			
03 Electronic Medical Record (EMR) Management			
EFFECTIVE DATE:	03/01/2014	**REVIEWED/REVISED:**	10/15/2014

- Treatment Plan & Crisis Plan
- Treatment Plan Addendum
- Treatment Plan Formal Review

The following is a list of the optional electronic forms that are available within LEO to providers/programs of LifeWays. It is understood that programs may utilize this form or their own forms until a standard consent is created for the entire CMH network. At that time, the LEO consents will become mandatory.

- Consent to Exchange/Release Information
- Consent to Participate in Services

Scanned Documents: If a particular electronic form does not exist in the system, the user may scan in their version of the form to complete the electronic record. It is expected that scanned documents are consistently uploaded using the appropriate category type to enhance the organization of these images. Each scanned document page shall include the consumer's name and case number. Additionally, the date of the scanned document shall match the date of the scanned image for historical archiving.

Timeliness of Signed Documents: Users shall recognize the importance of completing clinical documentation soon after the contact with the consumer. Unsigned documents negatively impact billing, encounter reporting, timeliness reporting, and other areas of performance. As a result, LifeWays has adopted a timeliness standard for clinical forms in LEO to be completed within 3 business days from the date of service. Therefore, clinical documents must be fully executed – completed and signed – within 3 business days of the date of service. The first exception to this rule are crisis interventions, which must be completed within 24 hours from the time of disposition. The second exception to this rule are progress monitoring notes for specialized outpatient services – specifically, RN, RD, BT, and OT services – which must be completed within 5 business days from the date of service.

Document Deletion: The agency maintains a position that the documentation in the EMR system must be of high integrity. Therefore, documents entered in the LEO system are considered part of a permanent record and shall not be deleted. The only exception to this standard is documentation that is done in error (e.g. wrong chart, duplication). If a document has been entered in error, the user shall report this to their Supervisor for deletion. If the Supervisor does not have permissions to delete that specific type of document the request for deletion shall be reported to the LifeWays IT Help Desk by the user's supervisor with a written request to delete (using the Help Desk module to enter a ticket), which signifies the supervisor's approval of the document deletion. A LifeWays System Administrator (IT Staff) retains all rights to deleting documentation and will only execute this task when written confirmation from the requestor's supervisor has been received and it is determined to be done in error. If there are identified patterns at the user level regarding the volume and frequency of requests to delete documents, the agency reserves the right to remove the user's access to the EMR and request a training plan.

SECTION		GOVERNING POLICY	
7.00 Information Systems (IS)		01 IS Infrastructure, Strategy and Management	
SUBJECT			
03 Electronic Medical Record (EMR) Management			
EFFECTIVE DATE:	03/01/2014	**REVIEWED/REVISED:**	10/15/2014

LifeWays shall evaluate compliance with these standards through periodic desk audits. The auditing results shall be used for corrective action and continuous quality improvement in an effort to support the integrity and proper utilization of the EMR.

TRAINING AND TECHNICAL ASSISTANCE

Training: The agency maintains the responsibility to provide training and education to users to support competency, system integrity, security and compliance with the EMR standards. Training can be conducted through various methods, including: live instruction, e-learning modules, written instructions with screen layouts, videos with screencasting, etc. The trainer of the content shall be a subject matter expert. LifeWays may user a peer or skilled training within a provider or program to transfer knowledge. Training needs shall be evaluated through an annual survey process. Requests for training can be made through the IT help desk at any time. The IT team will coordinate a training to occur with the subject matter experts.

LifeWays may request a corrective action plan if, after adequate training and technical assistance has been provided to the user, non-compliance with EMR standards and expectations remains. The Quality Improvement & Technology Division shall engage the Contract Management Team in any corrective action processes related to the EMR standards and expectations.

Resources: The agency shall supply various learning materials, such as written instructions, how-to guides, FAQs, tutorials or other forms of educational content that can be made readily accessible and utilized by the end-user when technical assistance or troubleshooting is needed.

Help Desk: If the user is unable to self-resolve the issue, the user shall contact the LEO Help Desk by calling 517-780-3367 (internal x2367) or submitting a ticket through the Help Desk module within LEO. The LEO Help Desk is intended to provide technical assistance and troubleshooting of system errors for traditional business operations that currently exist within the EMR. The agency shall maintain high standards for timeliness of response and resolution, and maintain open communication with the user regarding attempts made to resolve the help desk ticket. The LEO Help Desk is not designed to field system enhancements or suggestions from end-users.

Enhancements or suggestions for system improvement and modification shall follow a separate and formal change control process.

SYSTEM CHANGE CONTROL PROCESS

It is expected that the system will evolve and changes will be necessary as areas for improvement are identified. The agency shall maintain an organized process for receiving and implementing system enhancements. The following change control process will be followed for EMR system changes:

SECTION		GOVERNING POLICY	
7.00 Information Systems (IS)		01 IS Infrastructure, Strategy and Management	
SUBJECT			
03 Electronic Medical Record (EMR) Management			
EFFECTIVE DATE:	03/01/2014	**REVIEWED/REVISED:**	10/15/2014

Phase	Description of Systems Development Life Cycle
1. Initiation	Begins when a user identifies a need or an opportunity. The *System Change Request* form is completed. System analysis is conducted to validate the request.
2. System Concept Development	Determines feasibility. Defines the scope or boundary of the concept. Determines impact, expected outcomes and measures for success. The *System Change Request* form is updated.
3. Design and Planning	The functions and operations are described in detail, including screen layouts, business rules, process diagrams, and other documentation. A prototype is created for the Development system. The *System Change Request* form is updated to reflect the implementation and communication plan.
4. Prototype Testing and Pilot	The prototype is loaded in the Development system for user testing and training. Additional modifications are requested from the developer as necessary to meet the expected outcomes. Input is received from primary end users.
5. Implementation and Training	The tested prototype is deployed to the Production system on a scheduled date. End users receive communication and instructional material from the agency for training purposes.
6. Sustainment	The change is re-evaluated for success based on the previously defined outcome measures. Input is received from primary end users to determine success.

COMMUNICATION

The agency shall follow the change control process for system enhancements in order to effectively communicate with system users. Changes are communicated primarily through the LEO News Bulletin, which is published on the LifeWays website and emailed to the EMR List Serv (managed in Constant Contact). The Bulletin shall describe the purpose, description of the change and effective date. The agency shall release the Bulletin as official notice of a scheduled change. Changes will usually occur on the first day of the following month. Primary users shall be provided with the opportunity to test the change in the Development system and provide input before it is in the Production system. Bulletins will be archived on the LifeWays website for future reference and instruction. The agency will use the LifeWays Provider Meeting as a mechanism to communicate critical changes to the system, provide training and seek input.

SECTION		GOVERNING POLICY	
7.00 Information Systems (IS)		01 IS Infrastructure, Strategy and Management	
SUBJECT			
03 Electronic Medical Record (EMR) Management			
EFFECTIVE DATE:	03/01/2014	**REVIEWED/REVISED:**	10/15/2014

REFERENCES

U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
U.S. Health Information Technology for Economic and Clinical Health Act of the American Recovery and Reinvestment Act of 2009
LifeWays Operating Procedures
- 07-01.01 Data Validation and Management
- 07-01.03 Reporting Services
- 07-02.02 Information Access and Systems Security
- 07-02.06 Use and Disclosure of Protected Health Information
- 07-02.07 Mobile and Portable Systems and Security
- 07-03.02 Information Systems Service Desk

Forms
- LEO Systems Change Request

Attachments
- LEO Quality and Integrity Standards for Electronic Medical Records
- System Change Control Process Flowchart
- System Change Request form

LEO Instructional Materials

How-To Guides
- How to Update Consumer Demographics
- How to Add an Admission, Provider Assignment, Staff Assignment, and Discharge a Consumer
- How to Add an Initial Intake
- How to Add Consumer Notices
- How to Change a Signed Document
- How to Early Terminate an Authorization
- How to Navigate the Consumer Chart
- How to Add / Request Authorizations
- How to Update the Intake
- How to Update a Consumer's Diagnosis
- How to Add Consumer Allergies / Adverse Reactions
- How to Add DD Proxy Measures
- How to Complete a Service Activity Log
- How to Complete a CAFAS/PECFAS Assessment
- How to Use Discussions
- How to Use Electronic Labs

Flow Charts
- Access Center Screening Process Flow
- Access Center Intake Process Flow
- Utilization Management Process Flow
- PSU / Support Staff Process Flow
- Provider Clinical Process Flow

SECTION		**GOVERNING POLICY**	
7.00 Information Systems (IS)		01 IS Infrastructure, Strategy and Management	
SUBJECT			
03 Electronic Medical Record (EMR) Management			
EFFECTIVE DATE:	03/01/2014	**REVIEWED/REVISED:**	10/15/2014

Provider Claims Process Flow

FAQ

User Manuals
Login and Navigation User Manual
Access Screenings, Crisis Interventions, Intake Assessments User Manual
Treatment Plans User Manual
Service Activity Logs User Manual
Provider Claims User Manual
Provider Management User Manual
Calendar User Manual
Case Load User Manual
Sentinel Events User Manual
Death Report User Manual
Court Orders User Manual
Integrated Health Assessment User Manual
Consent to Exchange Information User Manual
Progress Notes User Manual
Medication Review Process
Incident Report Manual

HISTORY	
Effective 03/01/2014	Rev. 07/01/2014, 09/01/2014, 10/15/2014

LEO Quality and Integrity Standards for Electronic Medical Records

Effective: 8/1/2013
Purpose: The following table identifies the minimal standards necessary to determine an electronic medical record as complete and accurate.
Reference: LifeWays Operating Procedure: 07.01.03 Electronic Medical Record Management

Item #	Category	Indicator	Evaluation Criteria
1	AD	A staff assignment exists for each provider assignment.	There is at least 1 staff assignment under each provider assignment.
2	AD	Discharge pending approval is less than 14 days since author signature, or is absent.	Discharges present and pending UM approval are less than 14 days old.
3	AD	Open provider assignment has active authorization to serve the case.	There is a provider assignment for each authorized provider. Providers without active authorizations have been closed.
4	AD	Primary case holder is assigned for open case.	Open case has active primary case holder (staff) assigned.
5	AD	Primary provider is assigned for open case.	Open case has active primary provider assigned.
6	AS	If behavior treatment plan exists, BRMC case notes are present according to BTP review schedule.	Review the BTP for the indicated BRMC review schedule. The BRMC case review notes should be completed according to the specified BRMC review schedule.
7	AS	BRMC Case Review form is completed prior to discharge summary.	If discharge needs BRMC review, the BRMC case review form is less than the discharge form date.
8	AS	If child, CAFAS/PECFAS assessment has occurred in last three months.	If the consumer is age 7-17, a CAFAS score is present. If consumer is age 4-6, a PECFAS score is present. Score should be recently entered in the last 3 months.
9	AS	DD proxy measures have been completed in last 12 months.	If consumer has a DD disability designation, there is a DD proxy measure entered in the last 12 months.
10	AS	Assessment has occurred in last 12 months.	An intake or update assessment was completed within the last 12 months for open case.
11	AS	Health conditions are complete.	A selection is present for every health condition listed in the health & other conditions page.
12	AS	If consumer is authorized for a BTP, there is a BTP scanned into LEO	If consumer is authorized for H0032 BT there is a scanned BTP in the scanned document file.
13	AS	Psychiatric inpatient stays are managed through continued stay reviews and hospital discharge planning.	If psychiatric inpatient authorization is present, there is a continued stay review and hospital discharge from.
14	CR	Chart Notes are used appropriately for miscellaneous documents or chart warnings.	If a chart note is present in the record it is for miscellaneous purposes and not billable documentation or information that is applicably stored elsewhere.

Item #	Category	Indicator	Evaluation Criteria
15	CR	Consent to participate is present.	Consents to participate for all active providers are completed electronically or scanned into the record.
16	CR	If consumer is enrolled in school (K-12), there is consent to release information to the school present.	Consents to exchange/release info to the child's school is completed electronically or scanned into the record, and is current.
17	CR	If consumer reports a primary care physician, consent to release information to the physician is present.	Consents to exchange/release info to the physician is completed electronically or scanned into the record, and is current.
18	CR	Diagnosis Axis are complete (Axis 1-5)	The full diagnosis table is complete, including Axis I, II, III, IV, and V.
19	CR	Advanced Directive status is collected and scanned into the chart is active.	Review the most recent consent to participate. If the consumer indicates that they have an active advanced directive, a copy is scanned into the consumer chart.
20	CR	Scanned documents are appropriately categorized, organized and identify the consumer's name and case number.	Review each scanned document that was entered during the current treatment plan and verify that the Document Type appropriately matches the content of the scanned image. The date of the document should match the date within the document, and not the date it was scanned. There should be no duplication of scanned documents. Each scanned document contains the consumer's name and case number.
21	CR	Care coordination/communication form is used and scanned into LEO in accordance with consents to release info (i.e. beginning services, medication changes, hospitalizations, discharges)	Care coordination is evident by a health care coordination form document in the record.
22	CR	If guardian is present there is guardianship papers are on file.	If a guardian is indicated in the Consumer Information, there are guardianship papers scanned into the consumer chart.
23	CR	No documents awaiting disclosure in the Medical Record queue.	The requested documents have been released externally and are not pending in the Document Disclosure Queue.
24	CR	No unsigned documents awaiting signature.	All documents are fully signed and not pending a staff signature.
25	CR	Consumer appointments are managed through updates to the appointment status.	Review consumer appointments and verify that the status of any past appointments has been changed from Scheduled to Kept, Cancelled or No-Show.
26	DQ	Address is complete and accurate	Complete and accurate address define by valid Street, City, St, Zip, Home Phone
27	DQ	Emergency contact information is present.	Emergency contact is provided or Section not applicable.
28	DQ	Primary guardian information is present.	Guardian is provided or Section not applicable.

Item #	Category	Indicator	Evaluation Criteria
29	DQ	Preferred pharmacy information is present.	Pharmacy is provided or Section not applicable.
30	DQ	Primary care physician information is present.	Physician is provided or Section not applicable.
31	DQ	Absence of critical data errors.	Consumer chart is free from all data quality errors.
32	FI	A current self-pay (financial determination) is complete, verified by LifeWays.	Self-pay is present and includes the consumer's signature that is obtained digitally or is scanned in as an attachment to the policy. Supporting financial documentation is scanned in as an attachment to the policy.
33	FI	Insurance policies are verified.	All insurance policies for the case are Verified and not in Awaiting Verification status.
34	FI	Medicaid deductible policy is present if the consumer is on a deductible.	If the consumer is on a Medicaid deductible, there is a Deductible policy entered in the insurance policy area and it is not expired until the deductible no longer applies.
36	IR	Incident Reports are routed for signature and reviewed/signed in a timely matter.	Search IR module for all incident reports for the consumer and verify that they have been fully reviewed by all Reviewers as indicated by a Review Date next to each reviewer. (The Review Date should not be null.)
37	MC	Medication consents are present and include consumer and medical staff signature for all current medications.	Review the most recent Medication Review to determine the medications that are active, then review the Signed Medication Consents in the Medical Chart to determine if there's a signed consent for each active medication.
38	MC	AIMS worksheet is completed quarterly for psychotropic medications.	Review CMH Medications to determine if Psychotropic medications have been prescribed and evaluate if AIMS testing has been completed every three months since the effective date of the prescription.
39	MC	Allergies/adverse reactions have been completed in last 12 months.	Adverse reaction/allergies have been recorded within the last 12 months. If no allergies, this is accurately recorded as NKDA-No Know Drug Allergies as the "Drug/Allergen".
40	MC	Dispense notes are present for injectable medications.	If consumer is prescribed an Injectable Medication, dispense notes are present to record the dispensing at the frequency noted within the prescription.
41	MC	Lab results are scanned or electronically transmitted; results are reviewed by ordering physician.	If consumer has a Lab Order in LEO, there is a corresponding Lab Result that has been reviewed by the ordering physician.
42	MC	CMH medications are present and current, and align with the most recent medication review note.	Review last medication review and cross-walk with the CMH prescribed medications for accuracy and completeness.
43	MC	No lab results awaiting review.	There are no lab results for the case that are Pending Review in the medical chart.

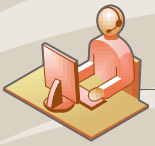
Item #	Category	Indicator	Evaluation Criteria
44	MC	Non-CMH medications are present and current (consumer self reports).	Review last medication review and cross-walk with the non-CMH prescribed medications for accuracy and completeness.
45	MC	Initial Psychiatric Evaluation is present.	A psychiatric evaluation is present.
46	MC	No verbal orders awaiting review.	There are no verbal orders awaiting the physician's approval for the case.
47	MC	Vital signs have been completed in last 12 months for consumers receiving Psychiatric services.	If authorization for medication review or psychiatric evaluation is present, there are vital signs recorded within the last 12 months.
48	PG	Progress notes are present for all active providers.	Review authorized providers and cross-reference with the progress note module. A progress note should be present for all active/authorized providers. The progress notes should be entered electronically if a e-format for the note is available; otherwise, a scanned progress note is accepted.
49	TP	Residential quality of life assessment was completed by residential staff prior to PCP meeting.	If consumer has specialized residential services (verify in demos and the treatment plan shell/header), there is a residential quality of life assessment included in the treatment plan and it was completed by the residential staff before the date of the PCP meeting.
50	TP	Consumer signatures are obtained digitally or scanned in as an Attachment to the Treatment plan.	Consumer's signature can be found within the Treatment Plan print or as a scanned document within the Attachments.
51	TP	Copy of treatment plan is provided to consumer.	Treatment plan shell (header) displays the date and method in which the copy of plan was provided.
52	TP	Notice of Hearing Rights is signed by consumer and scanned in as an Attachment to the Treatment plan (including subsequent Addendums).	Signed paper notice is scanned is as an Attachment to the treatment plan or plan addendum.
53	TP	Treatment plan formal review has occurred quarterly since treatment plan effective date.	A formal review was completed every 3 months, using the electronic form, since the treatment plan effective date.
54	TP	Treatment plan is fully signed by provider staff.	Treatment plan is entered electronically (not scanned) and is not pending staff signature.

[End]

Electronic Medical Record Management System Change Control Process Flowchart

August 1, 2013

1-Initiation
-Define need
-Initiate system concept
-Define scope
-Prioritize



LifeWays System Enhancement?

No

Refer to Help Desk / Close

Yes

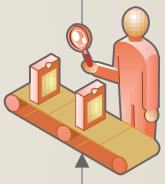
No

2-System Concept Development
-Assess value and feasibility
-Recommend solution
-Define impact and expected outcomes
-Define measure for success
-Schedule according to priority list

Approve Enhancement?

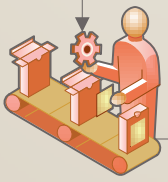
Yes

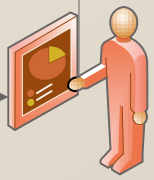
3-Design & Planning
-Define change
-Define purpose
-Develop screen layout
-Develop process diagram
-Develop instructional manual and business rules
-Develop screencasting video or training



6-Sustainment
-Re-evaluate change
-Seek input from primary users
-Subsequent revisions

4-Prototype Testing & Pilot
-Development system test
-Input from primary users
-Subsequent revisions





5-Implementation & Training
-Deployed to Production system
-Communicated through News Bulletin
-Training materials published on website

LEO System Change Request Form

Requested By:

Email:

Date of Request:

Identify Need & Initiate System Concept Development

A. Describe the problem:

B. Describe the recommended solution or concept:

C. Define the scope or boundaries of the concept:

D. Describe the impact, expected outcomes, and how success will be measured:

E. Does this enhancement fit into the LifeWays mission and values? ☐ Yes ☐ No

F. Does this enhancement fit into the LifeWays strategic plan? ☐ Yes ☐ No

G. Does a lack of the enhancement inhibit quality service delivery to the consumer? ☐ Yes ☐ No

H. Does the opportunity impact: *(Mark all that apply)*

☐ Quality ☐ Productivity ☐ Safety ☐ Customer Satisfaction

I. Rating:

1. Rate the **severity (S)** of the problem (The seriousness of the problem or condition (non-conformance) as it relates to the consumers and/or the internal/external customers.)

☐	5	Very High	Safety issue which poses potential harm to consumer and/or internal/external customers
☐	4	High	Ethical or quality issues that impacts service to internal/external customer(s)
☐	3	Moderate	Probably has a noticeable effect on internal/external customer(s) satisfaction
☐	2	Low	Slight chance of the internal/external customer(s) noticing the effect
☐	1	Minor	Unlikely internal/external customer(s) noticing the effect

2. Rate the **occurrence (O)** of the problem (the number of times the problem or condition (non-conformance) occurs during the defined process cycle, within the scope of the element.

☒	5	Very High	80% or more of the time
☐	4	High	60% - 79%
☐	3	Moderate	40% - 59%
☐	2	Low	20% - 39%
☐	1	Minor	0% - 19%

3. Determine the **number (N)** of consumers and/or customers affected (The number of consumers and/or internal/external customers affected by the problem or condition (non-conformance) during a defined period of time, within the scope of the element).

☐	5	Very High	80% or more of consumers
☐	4	High	60% - 79%
☐	3	Moderate	40% - 59%
☐	2	Low	20% - 39%
☐	1	Minor	0% - 19%

LEO System Change Request Form

Priority Ranking Score: **PRS = (S) x (O) x (N)**

Design & Planning

Description of design and planned change:

Purpose of the change:

Attachments:

☐ Screen layout
☐ Process diagram
☐ Instruction manual with business rules
☐ Screencasting video

Prototype Testing & Pilot

Development System-Effective Date: _____

Summary of input from testing and subsequent modifications:

Implementation & Training

Production System-Effective Date: _____

☐ Included in News Bulletin
☐ Training materials posted on website

Sustainment

Planned Evaluation Date:

Measures used to determine success:

Results of evaluation:

References: LifeWays Operating Procedure 07.01.03 Electronic Medical Record Management