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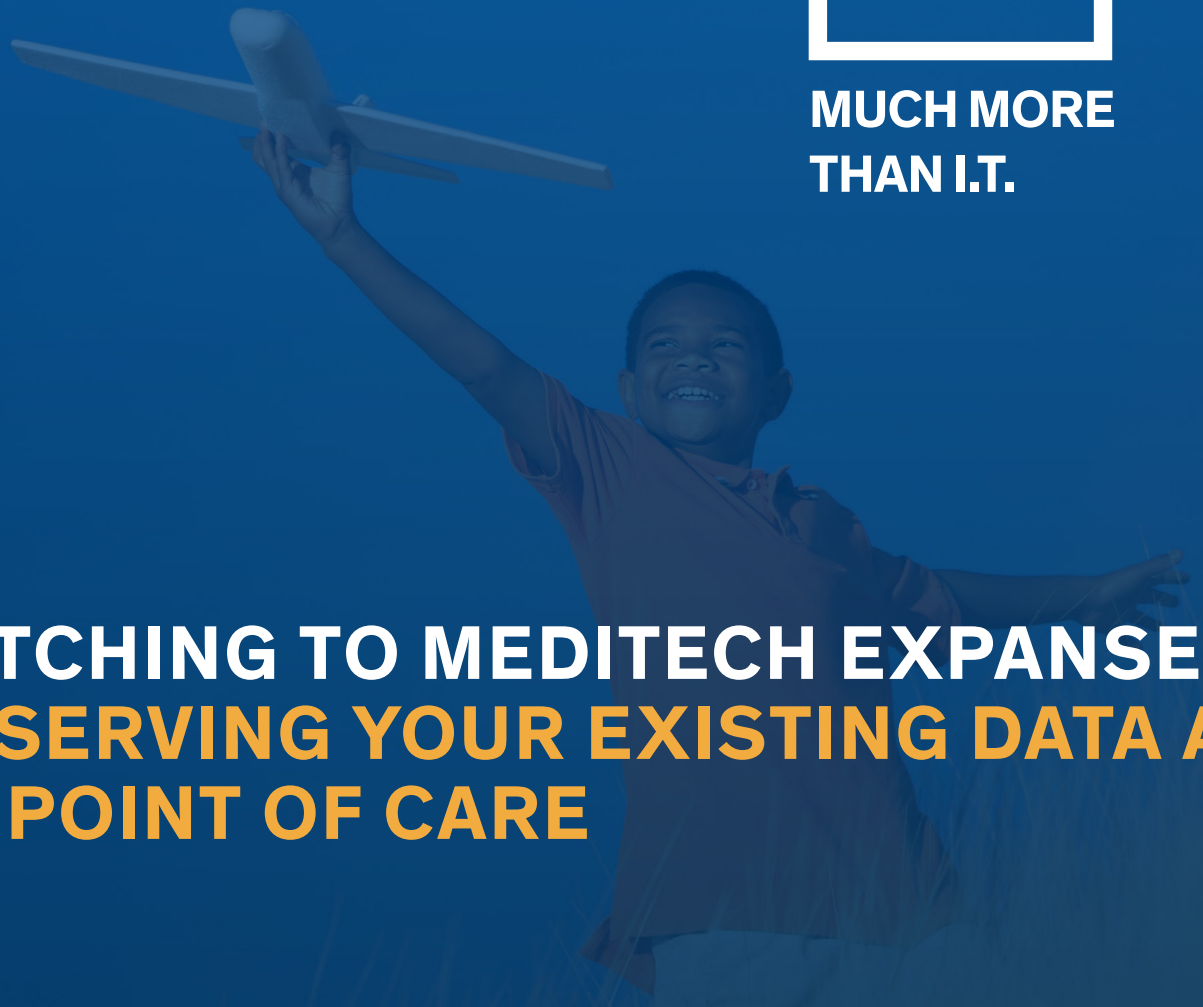

SWITCHING TO MEDITECH EXPANSE: PRESERVING YOUR EXISTING DATA AT THE POINT OF CARE

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ABSTRACT

DON'T FORGET OTHER VENDOR (OV) ACUTE AND AMBULATORY DATA IN YOUR MOVE TO MEDITECH EXPANSE

MEDITECH has delivered the next-generation, web-based Expanse platform that hospitals and health systems require to span ambulatory and/or acute care settings while reducing infrastructure and cost. As hospitals move to the Expanse ambulatory module, they can rely on MEDITECH to leverage services for implementation and MEDITECH-specific data migration. However, this leaves a gap for existing and prospective customers who currently use a variety of acute & ambulatory EMR and PM solutions.

Ensuring immediate clinical continuity and maximizing usability at Expanse go-live requires a thoughtful approach to both data migration of a configurable and clean subset of data regardless of the vendor AND coordinated legacy system data archiving, which provides legal hold, secondary clinical continuity (through single sign-on from Expanse), and important cost savings at legacy system retirement.

Key Takeaways:

Implementation of Expanse is of primary concern, but equal attention to data migration and archiving is worth it.

Data mappings and translations will drive improved end user experience and potential Expanse configuration requirements, and shouldn't be overlooked.

Data migration and archiving aren't mutually exclusive. Both are necessary in a move to Expanse.

Avoid risk! Ensure compliance with record retention mandates while reducing costs and properly decommissioning legacy systems.

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SWITCHING TO MEDITECH EXPANSE:
Preserving Your Existing Data at the Point of Care

Legacy System Options

Determining what data from systems can be migrated takes considerable understanding of all the options offered by MEDITECH and other third-party vendors. In addition, once a data migration strategy is developed, considerable effort should be devoted to governance, gaining feedback from and educating stakeholders about the data migration. Migrations support items such as the MPI, acute, and ambulatory clinical and financial data. They involve determining the value proposition of populating Expanse with data and how that data improves the continuity of care for providers as well as reduces the burden of data re-entry from clinical staff.

Timing the data migration go-live for the same time as the application go-live serves to "light-up" Expanse. Patient charts are populated with demographics, medications, and other clinical elements that facilitate continuity of care. In addition, reconciliation of migrated data allows staff and clinicians to gain familiarity with Expanse, specifically how to look up certain pieces of information.

Approach	Impact
Maintain Legacy Systems	• Provider dissatisfaction • High legacy system license, support, maintenance, & staffing costs • Lack of data accessibility
Document Management System	• PDF of clinical data provides snap-shot only & doesn't offer integration with normal workflow • Lack of discrete data resulting in release of information and clinical continuity concerns
Data Migration	• Minimize provider disruption through enablement of workflow and automation continuity • Minimize data re-entry costs and human error • Maintain discrete data analytics and clinical decision support capabilities
Data Archiving	• Provide additional revenue stream • Enable access to the data • Increased satisfaction

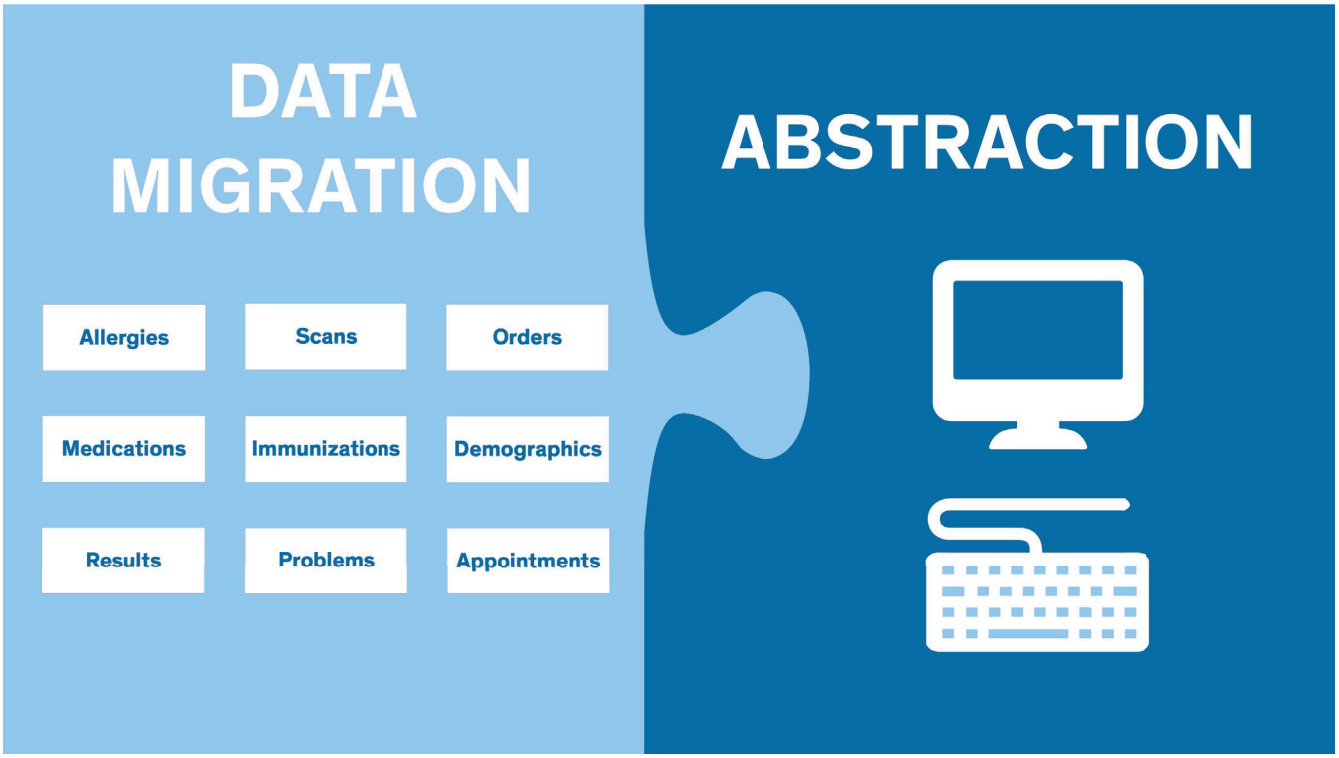
Data abstraction on its own, without data migration, is an error-prone, laborious, and flawed system transition strategy

Data abstraction entails the manual review of the data stored in the legacy system, sifting through it and determining which is essential and which is not ("stare and compare"). In practice, unfortunately, abstraction is highly susceptible to human error, and the fidelity of the data abstracted may be suspect.

It's certainly possible to bring over data in a manual, piecemeal fashion, such as when patients are seen, or in the case of some other reasonably predicable event. This will, eventually, patch up the gaps in data that may occur without a migration. If your organization is willing to suffer the significant, but probably short- to medium-term repercussions of temporarily losing this data in your EMR and related operational data repositories, then, migration might not be necessary.

When evaluating the choice between abstraction and data migration, decision-makers ought to focus on the cost and time-intensive nature of abstraction before adopting alternatives. Will it be possible for the organization to achieve its goals economically and on schedule? Often, a combination of data migration and abstraction is the best approach. Most organizations will find it impractical to electronically migrate or convert all legacy data into the new EHR – particularly if the data is not stored in a standardized format. But abstraction can be leveraged to supplement gaps in electronic data conversion that can occur when data is inaccessible or inaccurate.

When a legacy system is maintained for reference in addition to the go-forward system, productivity, user satisfaction, and quality of patient care can be compromised. Further, while manual keying of data can enable clinical continuity, it can also compromise data fidelity and accuracy, and often isn't feasible from an economic and timing standpoint. Another approach, once live on Expanse, is to reduce provider schedules and abstract at the time of the visit. However, this is laborious, and deters from directing attention to the patient at the encounter. For these reasons, data migration is the clear choice to enable continuity of care and return-on-investment.



A Programmatic and Proven Transition Process

Depending upon the scope, data migration projects can take anywhere from 6-18 months. The 8-phase methodology used at Galen has led to **hundreds of successful migrations** of all shapes and sizes. The basic framework puts an emphasis on mapping and validation, and, most importantly, feedback from clients.

PHASE 1	**DATA EXTRACTION AND EVALUTATION** Analyze data; identify potential risks	
PHASE 2	**DATA MAPPING** Goal is to map how these items will display in the target system moving forward	
PHASE 3	**SMALL SCALE TESTING**	
PHASE 4	**LARGE SCALE TESTING** (Two rounds)	
PHASE 5	**FULL SCALE TESTING** (Two rounds)	
PHASE 6	**GO-LIVE PREP**	
PHASE 7	**GO-LIVE**	
PHASE 8	**POST GO-LIVE SUPPORT**	

Risk mitigation is an essential component of Expanse transition. Below are the 5 most common risks:

1

DATA ACCESS

The single biggest hurdle to starting and delivering a project on time is obtaining required access to the legacy data. It's typically an afterthought, but once an organization starts to request access, the institutional knowledge needed for dependencies including granting database and front-end access to several in-scope applications can be elusive. This can be mitigated by organizations starting well before contract signature to identify who is able to grant and process the access.

2

OV SOURCED DATA

In the case that a OV is required to provide an extract of the data, such as a vendor-hosted application, it almost always results in the OV providing data that is incomplete, resulting in project delays and additive costs. This can be mitigated by requiring the legacy OV to provide full database copies throughout the project. In the event that a full database copy cannot or will not be provided, a detailed specification should be provided for review before data delivery. It should also be worked into the contract with the legacy OV that they will provide updated extracts for missing data at no additional cost and in a timely manner.

3

SUBJECT MATTER EXPERT (SME) AVAILABILITY

Institutional knowledge of the legacy OV system is critical to transition success. To mitigate this, it is important to identify an SME prior to contract signature for each in-scope application. This SME will need to be able to carve out dedicated time throughout the project to support the project team and this SME should be relied on to make decisions about data for the system in which they are the expert.

4

CLIENT VALIDATION RESOURCE AVAILABILITY

Client end users are generally tasked with many other priorities and responsibilities to provide validation support at the right time and in a prompt manner to support the timeline of the project. To mitigate this, advance notice of when validation resources will need to be available should be communicated and the organization will need to ensure that these resources are able to make the validation a priority at that time to maintain the transition project timeline.

5

BURNING PLATFORM COMMUNICATION

It is critical that all drivers for Expanse transition are clearly communicated. Examples include software license renewal dates for legacy systems, mandated pending hardware refresh dates, loss of data center or system access, and replacement system go live dates and transition timelines.

Simply migrating data to Expanse is not a sound retention strategy

The process of EMR data migration almost always results in some fundamental alteration of the legacy EMR data, most often because the underlying data models used by EMRs differ greatly from one another. Data retention is not a matter of export/import. Instead, it's a true ETL process – extract, transform, load.

Why? The shape of the data is changed. Data sets, such as order codes, result codes, diagnosis categories, note types, and various other types of dictionaries are mapped from the values in the legacy EMR to the values used by the new EMR. If done poorly, as in a number to a string, precision will be compromised. Fields that have no apparent corollary in the new EMR are often just ignored altogether. It's frequently not possible to know for sure what the data actually looked like in the legacy system once this process is complete and the legacy system has been sunset.

Even if the mapping is reasonably accurate, from a clinical perspective, is it useful to take 15 years of legacy data and load that directly into your new EMR? Most organizations opt for something more likely to be relevant, while still preserving patient safety, perhaps three to five years of data. The state and federal requirements for archival are vague regarding how long you need to preserve data (from six years to forever, depending on a variety of factors), and the regulations also don't remind you that the data you need to preserve should be limited to what is currently clinically pertinent. In other words, that 10-year-old test result may still, technically, be part of the legal medical record.

There are two other significant data sets that are rarely if ever included in a migration effort: audit trails and clinical item version history. Audit trails are fairly self-explanatory, and it would seem like a simple process to bring this over as part of a migration, but EMR vendors generally are not on board with customer manipulation of the legal audit trails in their applications. Virtually all forbid that type of data import. In many EMRs, it's possible to do a bulk export of this data and store it separately, perhaps in a spreadsheet, but correlating that audit data with contextual information that was in the EMR can be difficult.

COMMONLY MISSED DATA SETS

Contextual audit traits

Infrequently used / Invisible fields

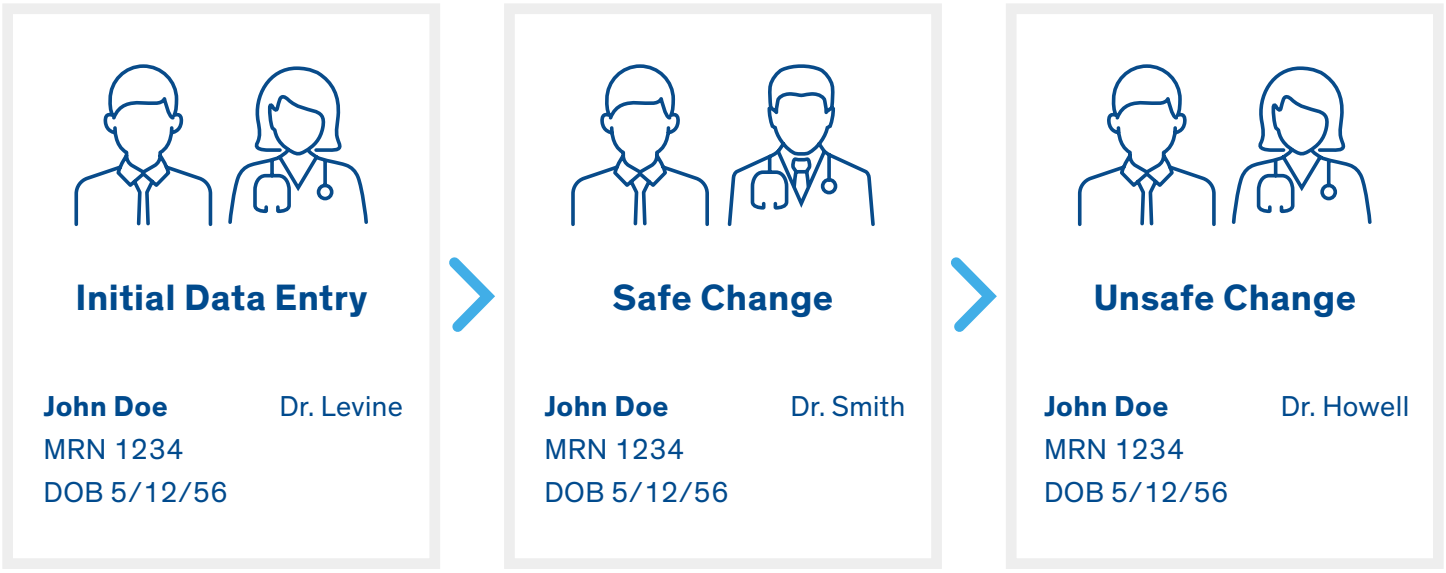
Data change / Version history

Referenced data in ancillary systems

- PACS
- Practice management systems
- Document managing systems
- Paper records

The other major data set not included in data migrations is the version history for individual clinical items. A common example of this occurs in the visit notes. Most note workflows include multiple edits. Perhaps a nurse starts the note as the beginning of a visit, a doctor adds some relevant content during the face to face with the patient, and another clinical staff member adds additional content after hours. Each time this note is saved, it's usually a copy that's saved.

There is a good reason for this – it shows who made exactly which changes, and it shows what information was present in the EMR at a given point in time. Clinically, the most relevant data is usually the most recent, though there are certainly exceptions to this. Legally, having that "point in time" view is frequently critical. That's one of the most important reasons virtually all EMRs do this type of versioning or change history for almost all important clinical documentation. It's also why your organization should not be quick to ignore this data during a retirement. It's possible, perhaps even likely, that you won't ever need it, but, as the sophistication of clinical documentation has increased, so too have lawyers' requests for information when litigating cases and issuing eDiscovery requests.



Solely archiving data is not a sound Expanse transition strategy

An archive-only approach means abandoning millions of dollars' worth of hard-won documentation and all the automation and analytics that went with it once the transition to the new EMR is complete. An EMR is a lot more than a place to store clinical documentation. Virtually all modern EMRs have substantial functionality surrounding clinical decision support, health maintenance planning, and quality reporting. They are also often crucial sources of data for analytics suites that are the pillars of population health management. In short, not maintaining the easy availability of this data inside the active EMR is akin to having used paper charts up until your latest and greatest EMR was available. That's not a reality that most organizations are comfortable with. One could certainly argue that much of the data in some EMRs, especially those that were implemented very early on in the transition to electronic records, contain a significant amount of "junk" data that ends up hurting more than it helps when migrated to a new system. Although that can be true, it also varies greatly on a patient by patient basis and making a decision to abandon all data due to some bad data is rarely sound.

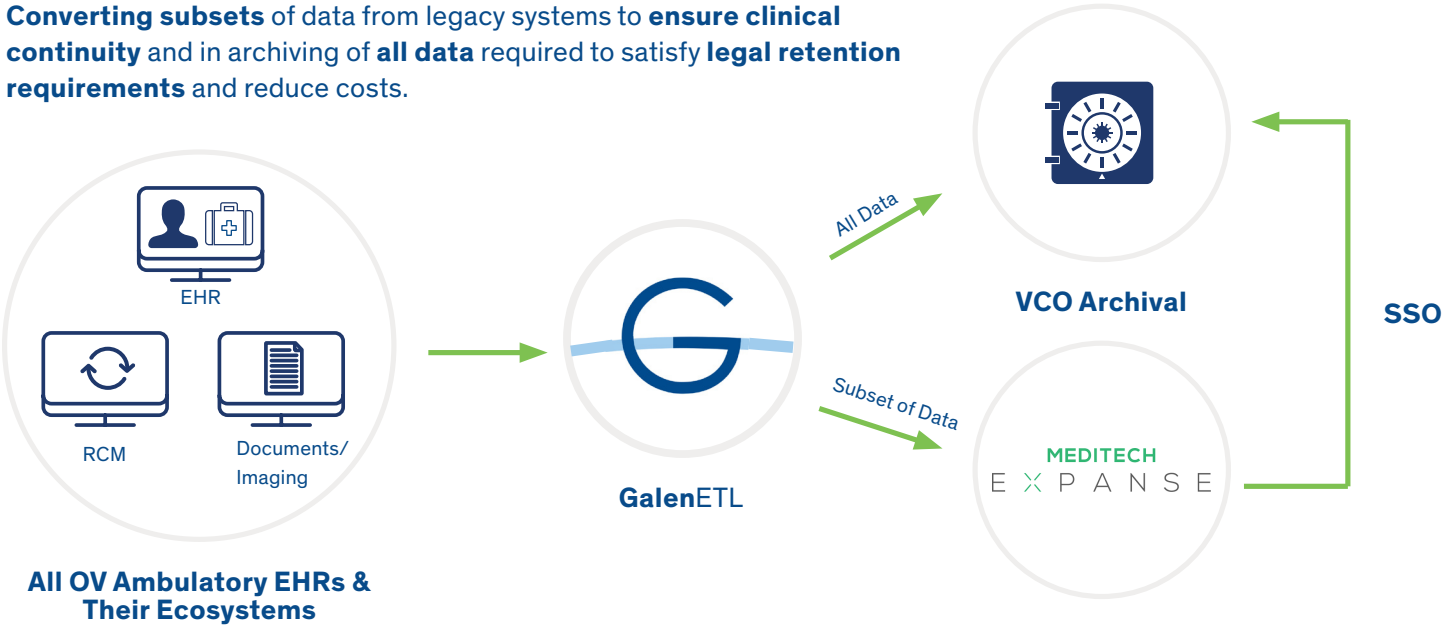
"DIRTY DATA" - Migration copy and change a subset of data and are limited by:

- **Import mechanism** (CCD vs HL7 vs. direct database)
- **Time range** (field/dictionary mapping, data types, etc.)
- **Level of data fidelity** (field/dictionary mapping, data types, etc.)
- **Data set** (problems, allergies, meds, etc.)

The value of coordinated data migration and archiving planning, scoping and strategy

They are equally necessary in:

Converting subsets of data from legacy systems to **ensure clinical continuity** and in archiving of **all data** required to satisfy **legal retention requirements** and reduce costs.



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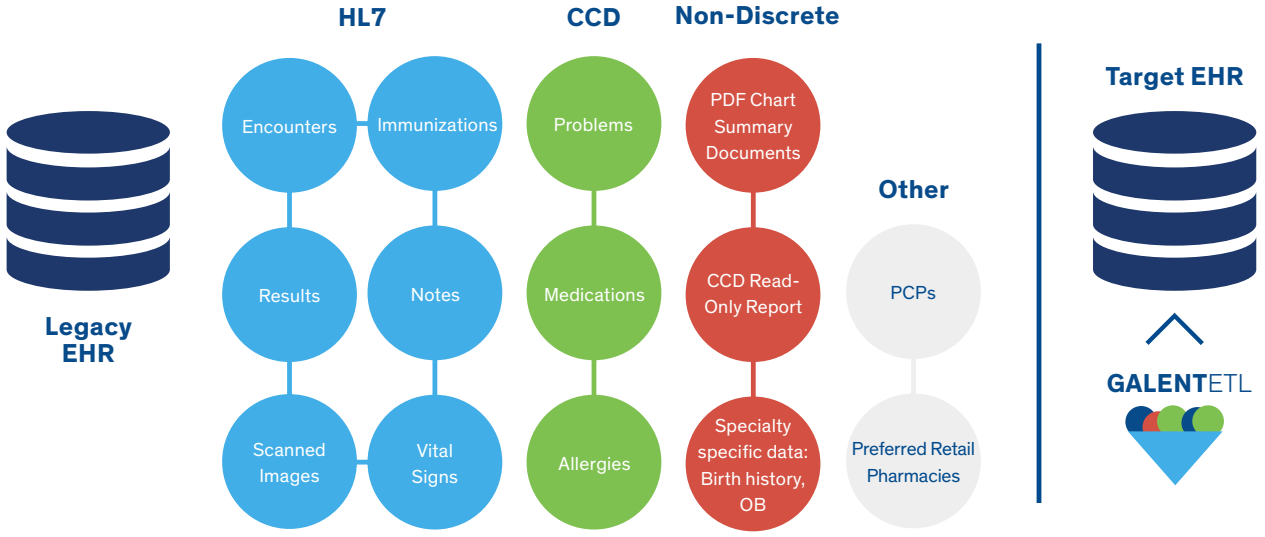
Data migration and archiving can be complex, costly, and resource intensive. While the primary focus may be on implementation of the new system, an equal amount of attention must be directed to data migration and archiving – especially with regard to contract expiration and extensions. Many areas of the organization are affected, and it's important to gain feedback and consensus from stakeholders.

Formation of a Physician Advisory Council can be effective to ensure proper data governance. Some of the considerations for planning, scoping and strategy include:

- How am I going to access legacy patient data?
- What data will not move to the new HIS system?
- Are our processes fine-tuned enough to be down for a full day?
- How are business offices going to continue to collect revenue?
- Does the reporting software allow me to combine data from multiple systems?
- Do I have enough resources to cover extended trainings and existing maintenance?
- How much am I going to be paying each month in maintenance for my legacy system?
- How long do I need to license the legacy system before pursuing decommissioning?
- How will downstream systems be affected by new patient identifiers?

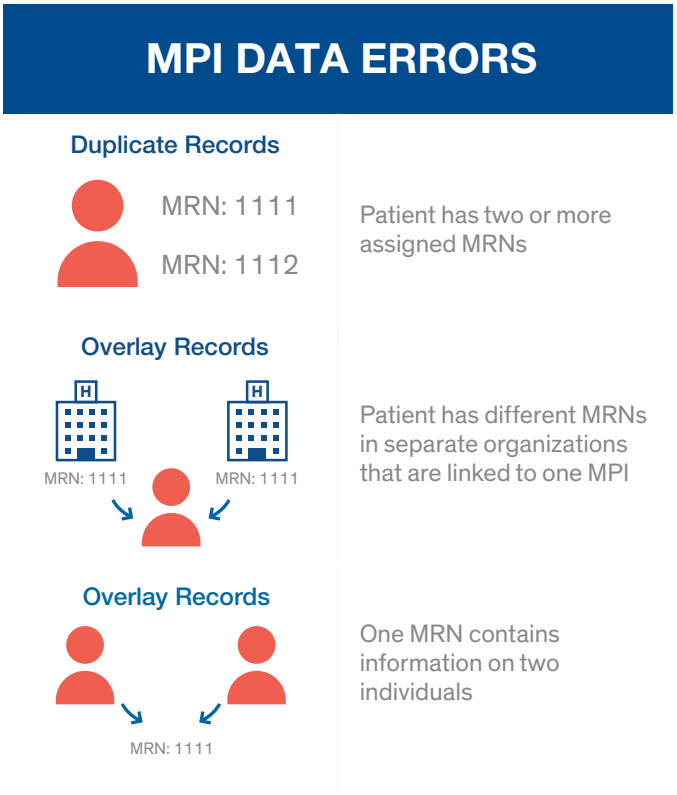


Enterprise Master Patient Identifier and patient matching

Research shows that healthcare organizations without an EMPI have an average duplicate patient record rate of 18%. This costs a hospital on average $1.5M annually.

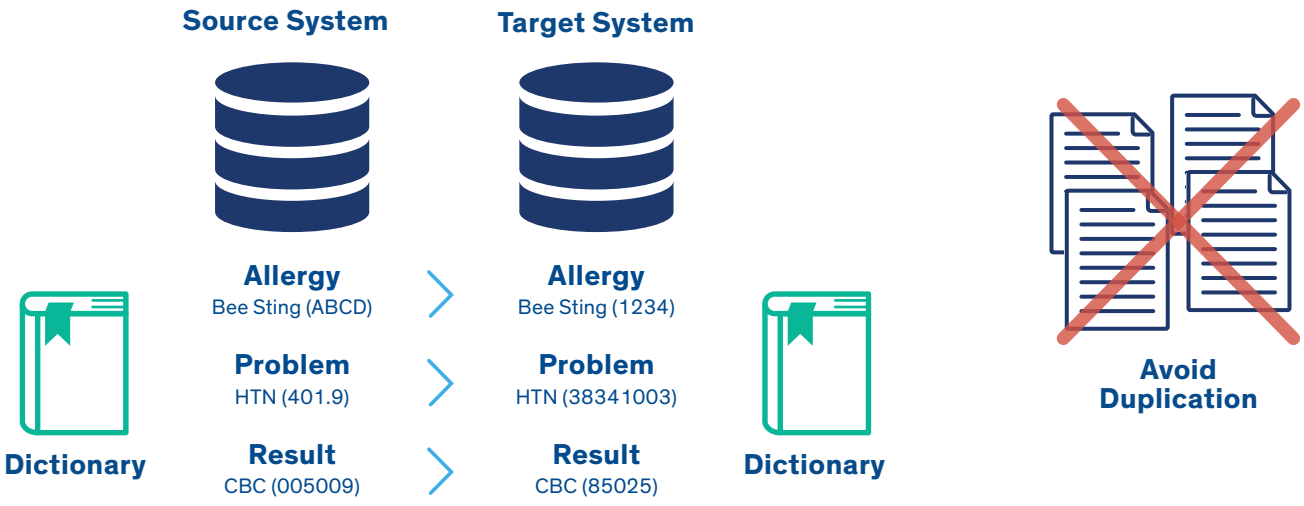
When migrating from OV systems, robust patient identification is needed to limit patient duplicates. It's a critical component in the data migration strategy to ensure data fidelity and accuracy, as well as patient safety. The ability to track and correlate patient IDs across legacy systems enables a more comprehensive view of a given patient, minimizing medical errors, decreasing billing issues, and improving information sharing.

For these reasons, its important to come up with a robust EMPI and patient matching strategy during data migration scope. The GalenETL data migration platform achieves precision in patient identification across legacy systems through identification and merging of duplicates and generation of a unique identifier to be used for import into Expanse. In addition, legacy system patient identifiers are maintained as alternate patient identifiers for a holistic view of the patient record.



Clinical data mapping

Data mappings and translations are major components in the execution of a clinical data migration and will ultimately drive the end-user experience and potential configuration requirements of the target system. It is important to recognize that data migration is not just a matter of export/import; table definitions are not one to one, especially for older platforms. Data sets, such as order codes, result codes, diagnosis categories, note types and various other types of dictionaries are mapped from the values in the legacy EMR to the values used by Expanse. Because native EHR vendors often fall short with regards to semantic management, semi or full automation of dictionary, nomenclature and ontology mapping are critical to the reduction of manual effort and invaluable for continuity of care. Probabilistic or machine learning solutions can address the majority of mapping requirements, leaving a subset of exceptions to be addressed manually.



OV AMB Reconciliation

OV Ambulatory clinical data data can be discretely imported into Expanse and reconciled through "Clinical top off file. " Below are the details for the different clinical data elements supported.

ALLERGIES

Allergies are filed at the Medical Record level and for interaction checking to occur they must be filed with a First Databank Allergen identifier. Uncoded Allergies are filed as Free text. Net new Allergy data included in the clinical top off file will be processed and filed in the same manner as the initial clinical file. If a specific Allergy included in the top-off file exists on the patient record from any other source, that specific Allergy will be updated/overwritten with the details for that Allergy included in the top off file.

HOME MEDICATIONS

Patient Active Home Medications are filed at the Medical Record level in an external medication reconcile area. Net new Home Medication data included in the clinical top off file will be processed and filed in the same manner as the initial clinical file. If a Home Medication, included in the too off file, exists on the patient record from any other source, that Home Medication will be duplicated and may appear twice in the medication reconcile area.

PROBLEMS

Problems are converted and filed at the Medical Record level and filed directly to the Problem section of the patient record (if IMO coded), or to External Problems which need to be reconciled (if not IMO coded). Net new Problem data included in the clinical top off file will be processed and filed in the same manner as the initial clinical file. If an IMO coded Problem, included in the clinical top off file, exists on the patient record from any other source, that problem will be duplicated on the problem list. However, in the event the IMO coded problem included in the clinical top off was previously loaded using the OV AMB Problem conversion and the identical Problem Number (Field 13) is utilized, the conversion will identify that as a duplicate. In this case the problem file for that patient will error out and none of the problems included in the clinical top off file will be loaded. If a problem in the clinical top off file is to be filed to the External Problems and it exists on the patient record and has previously been reconciled, it will not be filed as a duplicate but instead will appear on the registry report as a duplicate.

IMMUNIZATIONS

Immunizations are filed at the Medical Record Level and can be filed directly to the Immunization section of the patient record, or to an external reconcile area. Net new Immunization data included in the clinical top off file will be processed and filed in the same manner as the initial clinical file. If an Immunization (CVX code and Administration date), included in the top off file, exists on the patient record from any other source, that Immunization will not be filed and instead will appear on the registry report as a duplicate.

FAMILY HISTORY

Family History Problems (i.e. problems documented for relatives of the patient) are filed at the Medical Record level and filed directly to the Family History section of the patient record. Net new Family History problems included in the clinical top off file will be processed and filed in the same manner as the initial clinical file. For any Family History problem included in the top off file, a new Family member will be created, even if a Family Member Identifier and Relation matching what was in the initial clinical file is used. For example, if the initial file included Father with history of diabetes, and the clinical top off includes Father with history of asthma, the clinical record in Expanse would include two Fathers, one with problem diabetes, and one with problem asthma. If a family history problem, included in the top off file for a specific family member, exists on the patient record, it will be filed as a duplicate history problem and a duplicate family member.

VITAL SIGNS/CLINICAL QUERIES/SOCIAL HISTORY QUERIES

Vital Signs and other Clinical Query data are filed to a specific patient account and with a unique query instance identifier. Net new Clinical Query data included in the clinical top off file will be processed and filed in the same manner as the initial clinical file. If a specific query matching to a patient account and unique query instance identifier is included in the top off file it will overwrite the query value previously provided in the initial clinical file. If Clinical Query data is being provided for Accounts/Visits that were not part of the initial MPI conversion file, an MPI top off file will need to be loaded first in order to establish the Account/Visit the Clinical Query data is to be filed on.

HEALTH MAINTENANCE

Health Maintenance items are filed at the Medical Record level and filed directly to the Health Management section of the patient record. Net new Health Maintenance data included in the clinical top off file will be processed and filed in the same manner as the initial clinical file. If a Health Maintenance item, included in the top off file, exists on the patient record from any other source, a check will be performed on the last done date. If the date included in the clinical top off file is more recent than the date on the patient record, the date will be updated. Otherwise if the date is older, it will be ignored, and nothing will be filed/updated for that Health Maintenance item.

Validation

Not to be overlooked, one of the most important keys to a successful Expanse data migration is the validation effort. Validation can be broken down in five steps:

UNIT TESTING
ensures that each element of the data conversion from the legacy system to the target system is confirmed prior to hand off to the clinical team for validation.

SMALL-SCALE VALIDATION
targets common issues utilizing a small sample set of patients (usually ten patients). This ensures that large-scale validation can be maximized to find less common issues. Looking at patient-level data elements also helps to ensure that everything in scope for the data migration is being captured.

LARGE-SCALE VALIDATION
along with full-scale validation are collaborative efforts. As problems are identified at the element level, they are worked on by the tech team and then retested, ensuring that the issue has been corrected and no new issues have been identified. This round of validation also focuses on workflows, ensuring that each data element is functioning correctly while working through patient charts.

FULL-SCALE VALIDATION
encompasses the entire patient population. The goal is to test the extraction, timing, delivery, and loading of all the live patients in scope to a test environment that closely mimics production. This gives the data migration team time to identify and work any errors before the final load into production. It also allows for one last sample set of patients to be validated to ensure issues have been fully resolved.

GAP LOAD VALIDATION
is similar in nature to full-scale validation. However, a smaller data set is used to capture the information that is added to an EHR after the initial extracts are taken in preparation for end user go-live. It is the last round of validation for a data migration.

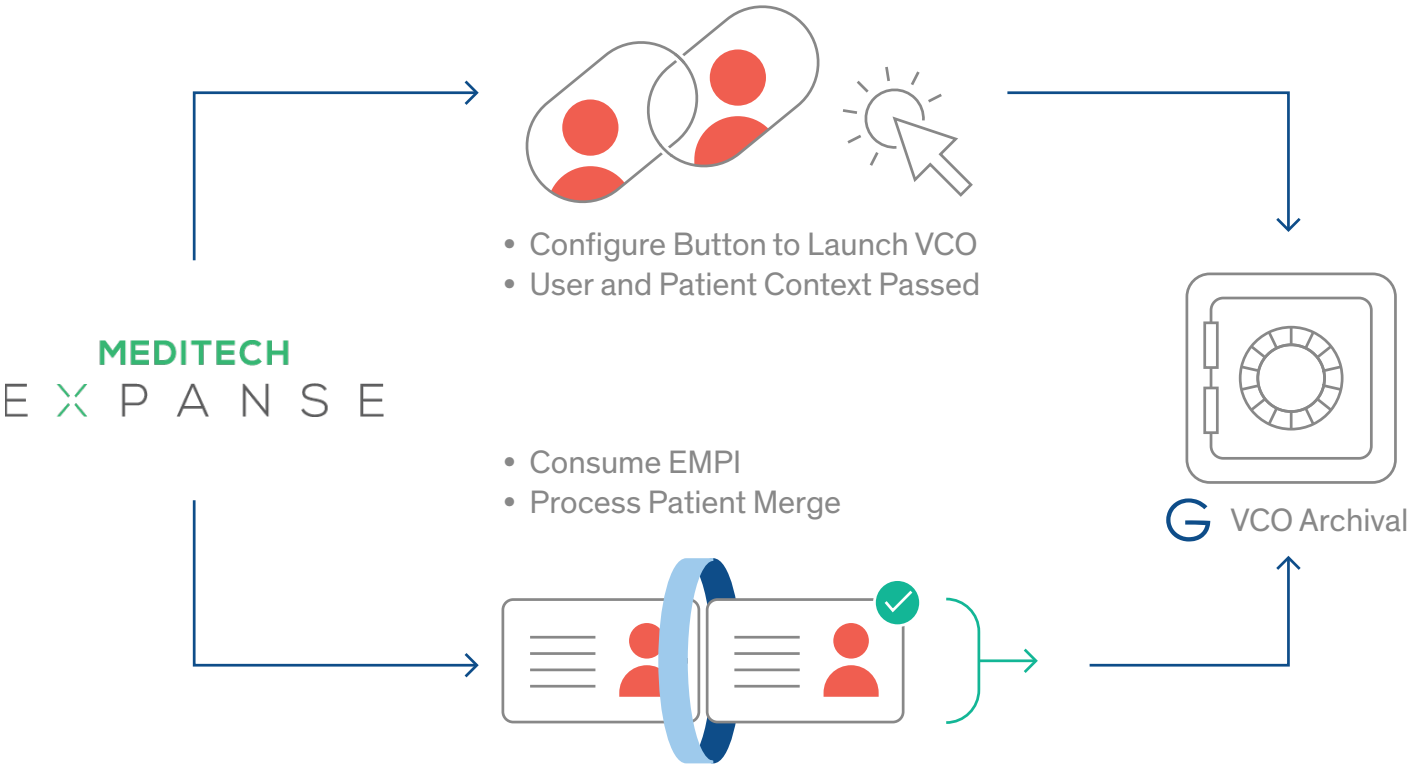
Legacy system decommissioning and data archiving

The reality of data archiving is much more complicated and challenging than the perception that it is a trivial data back-up. In fact, archive solutions must retire not just core applications such as the EMR, and EHR, but LIS, RIS, and ERP, while making the data accessible, accurate and secure. In addition, a chart summary PDF of clinical data provides a snapshot only, failing to integrate information with normal workflow and inadequate to eliminating concerns about release of information and clinical continuity.

The data that must be accessed is often sought by various departments (clinical, financial, administrative), each with its own set of needs and functional requirements for the post-production data lifecycle. The challenge for each organization is therefore to employ a records management strategy that ensures accessibility, security, and legal compliance, all at once, even though an organization's capacity to preserve the integrity and completeness of the original record, especially the ability to recreate a copy of the record as it existed at the relevant time in question, may be compromised when legacy systems are decommissioned, and legacy data is archived. The ability to access robust legal and clinical archives can be affected by approaches to extraction, transformation, loading and storage of data. A best-practice, risk-averse approach should provide the same level of access for all archived systems and data sets and the most cost-effective approach to the storage of legacy data without compromising accessibility or risking liability. This can be achieved with SaaS-native healthcare data archiving platforms designed from the ground up for the cloud.

Clinical usability - Single Sign-On from Expanse to data archiving system

VitalCenter Online offers a combination of SSO, direct, and hybrid login methods, enabling seamless access to domain users (Clinician and PM roles) and provisioned access to external users (Auditor role). Access to the VCO is available internally and directly from Expanse by utilizing a hyperlink that facilitates SSO integration and maintains patient context from the source system to VCO. Access to VCO is also provided to external users by accessing a customer-defined domain address (custom domain).



Reducing Total Cost of Ownership through legacy system retirement

The maintenance of legacy systems comes with inherent risk and additional cost. Compliance with record retention regulations requires HIPAA-compliant medical data storage ranging anywhere from 7 to 25 years based on medical specialty or state mandate. In addition to servers aging, software applications must be maintained with the latest upgrades. Users who know how to navigate the legacy system may leave the organization for a new job. Maintenance of the legacy system not only poses a technical risk for the organization, but it also extends the related costs and labor burden. Should release of information be required to fulfill a request from a patient, lawyer, employer, payer, or auditor, the patient clinical and financial history is legally required to be secure, accessible, discoverable, and easy to share in a HIPAA-compliant format. To avoid risk, ensure compliance with record retention mandates, and reduce costs, legacy system decommissioning and data archival are important components of any system replacement.

LEGACY SYSTEM COST COMPONENTS

System license/SMA costs	**Hosting costs** (if vendor/3rd party hosted)
Minimal license	**Staffing costs**
Upgrades	**Internal support**
Hardware costs (if hosted on-premise)	**General IT/ administration**
Annual maintenance	
Expected upgrades (such as OS migration/ new hardware iterations	
Infrastructure maintenance	

CLIENT Q&A
BEST PRACTICES & LESSONS LEARNED

WHY PERFORM AN OTHER VENDOR (OV) MIGRATION TO EXPANSE?

We made the decision to carry out our migration with Expanse to eliminate the expenses of maintaining another system, and to achieve one chart/one all-inclusive record for clinicians and Medical Records. If we had NOT done a data conversion, we would have had to pay staff to manually input data, which is costly and risky given possible data entry errors.

The data conversion has allowed providers to return to full schedules more quickly.

If your organization utilizes a product that is not built or supported by MEDITECH, when you Go Live with Expanse your providers are faced with a blank slate when utilizing the new platform. There is reduced efficiency in patient care and potential provider frustration in navigating multiple platforms. Migrating that data makes a difference in the ability to achieve increased provider satisfaction and return to full utilization

WHAT WERE THE MOST DIFFICULT PARTS OF THE MIGRATION PROCESS?

Finding the time and resources, while working with end users to get a clear decision and guidance on what the data should look like in the EMR, and how it should be managed once in the EMR. For example, it took time for the PAC (Provider Advisory Council) to decide whether to pull in all patient problems and determine how they should file in - unconfirmed, etc. You cannot make decisions around conversions in a silo.

IF YOU HAD TO START THE MIGRATION PROCESS OVER WHAT WOULD YOU CHANGE?

If we were to start over again, we would dedicate more time and resources (and money) to the process.

We often encounter this scenario across many of our migration projects where, in addition to all the other projects and phases that support the implementation to a new clinical EMR, the data migration requires more time and resources than originally intended. Galen Healthcare Solutions' data migration team's primary goal is to support as much of the migration project that is needed to ensure success of the migration project, but also the overall implementation project. We offer a full complement of services from project management, to validation, to data extraction and data evaluation.

CLIENT Q&A
BEST PRACTICES & LESSONS LEARNED

WHAT WERE THE DRIVING FACTORS IN DETERMINING THE DATA ELEMENTS IN SCOPE FOR YOUR MIGRATIONS?

First, we were limited by data elements our EMR vendor (MEDITECH) could accept. Secondly, though our EMR could have accepted many more clinical queries, we had to focus on what was most important as we could not review and map every element in the database.

As with most migrations, the data that we can extract from your EMR limits you in what you can bring over to your go-forward EMR. However, MEDITECH Expanse continues to evolve and now supports these data elements:

- Home Medications
- Allergies
- Immunizations
- Vital Signs
- Problem Lists
- Family History
- Social History
- Health Maintenance
- Document Images (Notes and Scanned Documents)

WHAT SPECIFIC TASKS IN THE MIGRATION DID YOU OVER/UNDERESTIMATE THE AMOUNT OF TIME AND RESOURCES THAT WERE NEEDED?

We underestimated the time and resources needed for conversions. We had an MPI (Master Patient Index), six clinical data sets (Problems, Medications, Allergies, Clinical Queries, Family History, Immunizations), and document image conversion. We assembled a multidisciplinary team that was comprised of Information Systems (both technical Integration and Informatics), HIM/Medical Records, and Galen Healthcare Solutions for technical support. Each person had a role and duties during the process while also being involved in other aspects of the EMR build. It was challenging while also keeping the rest of the EMR build in the know on what the output would translate to in the EMR (including our PAC-Provider Advisory Council), and the end users that needed to prepare charts (before the patient was seen). The chart preparation was an important component so that the provider could have complete information to be efficient.

The timing of these activities in the project were critical. We engaged with Galen Healthcare Solutions to assist with the conversion project, and their resource was key to our success. They were familiar with our EMR (MEDITECH) and their conversion specification, so they greatly assisted with mapping this process out, while completing the technical steps to meet the EMR conversion requirements. Galen advised the team on keeping a clean data set from our Other Vendor System (Medent), identified mapping and other technical issues, and were able to quickly address assurance of data integrity.

We are here to help you maintain the value of your clinical data across EMRs. MEDITECH Expanse has delivered its clients a single EMR platform across care settings, and we want to partner with you to help take advantage of data that has already been entered into existing EMRs.

Appendix A – MEDITECH Import Specifications for Other Vendor Ambulatory Data Conversions

Type	Item	Notes
Discrete Data	MPI with Historical Encounters/Accounts	Ability to convert patient level data along with historical visit history. A common patient identifier is preferred to minimize duplicate patient records.
Discrete Data	Allergies	Allergies are converted using an FDB Allergen Identifier and identifying a Severity of Mild, Intermediate, Severe, or Unknown.
Discrete Data	Problem List	Problems are converted using an IMO Concept ID Problems can be identified as Acute, Chronic, Suspected, Ruled Out or Inactive and with a Category of Medical, Surgical, or Social History.
Discrete Data	Vital Signs/ Clinical Queries	Vitals and Query data are converted using query mapping and like type queries.
Discrete Data	Family History	Family History is converted using an IMO Concept ID and includes the Family Member Relationship.
Discrete Data	Health Management Items	The Last performed date and next due date for Health Management items will display once a Protocol including that item is added to the patient's chart.
Discrete Data	Immunizations	Immunizations are converted using a CVX code and filed to an External Reconcile area and must be reconciled to be added to the patient chart.
Discrete Data	Social History Queries	The last instance of a Social mapped query response can be converted.
Discrete Reconcilable Data	Home Medications (Active List Import)	Active Home Medications with an RXCUI code are converted to an External Reconcile area and must be reconciled in order to be added to the patient chart.
Static View Only Data	Scanned Documents	The OV SCA Conversion can be used for Acute and/or OV Ambulatory to bring over reports, images, and data that are in a third party system. A Third Party would be used to stream the data out of the OV source applications, convert into a single page image format (.tif, .png, .bmp, etc.) meeting the R1375 spec to send to MEDITECH Expanse. The converted documents would be available in the Web Chart, EMR and HIM eChart.

Appendix B – MEDITECH Import Specifications for Other Vendor Acute Data Conversions

Module Code	Name	Description
RCG	Revenue Cycle	Full billing detail conversion
HIM	Health Information Management	MPI visit history, medical record numbers, demographic info.
ABS	Abstracting	Case mix historical information. MEDITECH recommends converting up to 7-10 years of information.
FA	Fixed Assets and Accumulated Depreciation	
GL	General Ledger	Actual and budget numbers
MMAP	Materials Management	Vendor, item, and stock
PP/HR	Payroll and Human Resources	Employee demographics, YTD balance
BBK	Blood Bank	Historical Information
PTH	Anatomical Pathology	Historical pathology specimen information
IDM	Imaging and Document Management	Exam history, impression text
SCN	Scanning/Archiving	Electronic legal record