Embracing the EHR's Challenges and Benefits: Grace Award Winner Reviews EHR Implementation Best Practices

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The University of Wisconsin Hospital and Clinics' (UWHC) motto of "great information, great care" has been the underlying force behind their health information technology (IT) adoption achievements since 2008. Besides attaining the highest level of the Healthcare Information and Management Systems Society's (HIMSS) Electronic Health Record (EHR) Adoption Model-stage 7-UWHC has successfully implemented a myriad of health IT resources including interfaces and electronic document capture. Other advanced initiatives UWHC has successfully implemented include innovative technology like palm vein scanning, which quickly and accurately identifies patients. They have also implemented an electronic portal that allows patients to access their health information and referring facilities to fax key patient information into the organization. This technological advancement helped UWHC win the first AHIMA Grace Award in October 2012, which honors healthcare facilities that demonstrate effective and innovative approaches to using health information while delivering high quality healthcare. UWHC moved to a complete EHR in 2010 when they decided to stop creating paper records.

But the road has not been easy, from the initial rollout of electronic access to the implemention of electronic lab, radiology, and dictated documentation in the 1990s. Though committed to their health IT adoption path, UWHC had to overcome many challenges. These challenges were met through the development of best practices that enabled an efficient process for incorporating outside documentation into their EHR.

Scheduling and Exchange Motivate Change

As a large teaching facility with over 80 outpatient clinics, UWHC treats many patients referred by primary care physicians outside the system. Patient access to specialists through timely appointment scheduling was identified as a critical need. In order to schedule the appointments appropriately and provide follow-up to the requesting physician, referral information needed to be made available electronically in the EHR as quickly as possible.

Scheduling a patient referred to UWHC was previously difficult for referring physicians. UWHC has numerous clinics with different phone and fax numbers with varied processes and criteria to schedule appointments. When outside documentation was needed in order to schedule an appointment, there was not a consistent, centralized process to ensure the information was available at the time of scheduling or available to the physician at the time of the appointment. Sometimes the documentation arrived in the clinic via fax or at the physician's office via mail. If sent to HIM for scanning, the records were sent via inter-departmental mail that resulted in scanning delays. Due to the volume of outside documentation received daily, identifying which documents needed immediate scanning was not always easy. To further add to the delays, some information was not received until the patient hand-carried it into the facility for their appointment. Each of these factors contributed to scheduling delays that led to physician and patient dissatisfaction.

Inconsistent Record Delivery Challenged Staff

Given these issues, UWHC set out to achieve electronically available referral information within the EHR. However, they had to overcome other challenges first. A major challenge included the delays in getting paper documents to HIM for scanning. The HIM department is located approximately seven miles from the main hospital, and over 20 miles from some of its clinics. Documents were sent to the HIM department by various methods:

- Interdepartmental mail (relies on the physical transportation of paper across town)
- Faxing
- United States Postal Service mail

- Placing the documents in a paper record pickup location for delivery to the HIM department by the Transportation Department

These delivery systems were too unpredictable to be consistently counted on. Another challenge was the re-faxing of faxed documents, which resulted in a decline of the scanning quality and impacted the overall integrity of the data. Lastly, duplicate information was being sent to different locations within the hospital and clinics that increased the potential duplication of scanned documents if not caught during the quality review process.

Form Processes Adapted

To improve the success of the referral program, a UWHC internal multidisciplinary group called the Clinics Access Collaborative formed in 2008 that included representatives from senior administration, medical staff, nursing, access services, and provider relations. The group started their work by creating a single standardized one-page referral form, and then piloted the new process. Next, they identified that improvements were needed in the handling of the initial referral information as well as the additional health record information received from outside facilities. The HIM department was invited to participate in this group in 2009 and worked to improve EHR documentation.

The referral form was originally designed for printing and faxing. But it was modified and made available on the UWHC website for direct entry. Two additional forms were designed to communicate back to referring providers regarding appointment status and the need for additional information. The appointment status form is a communication tool to notify the referring physician of the details of their patient's appointment. The request for additional information form is to notify the referring provider that additional information is needed in order to schedule an appointment with the correct specialist in the correct timeframe. Each of these forms contains the fax number of the HIM department to ensure that the documentation is properly imported into the EHR. The website provides information on direct entry or faxing of referral requests, as well as a clinic phone listing if the referring physician prefers to call. As each new step was rolled out, the overall process was continuously tweaked and improved. Process improvements continue today at UWHC. Process changes for the handling of outside documentation included:

- Simultaneous electronic distribution of the referral request to the access services and HIM departments
- Allowing for verification of insurance, assignment of a medical record number, and immediate referral to the appropriate clinic by registration staff
- Ability to upload the referral documentation into the EHR within minutes of receipt for immediate access by the scheduling clinic
- Providing referring facilities with a direct fax number to the HIM department
- Importing all documents electronically into the EHR from a fax queue without printing. The fax queue is now continuously monitored, resulting in an extremely efficient process that gets outside documentation imported, indexed, and available in UWHC's EHR within minutes of receipt

Today, the HIM staff utilizes the new processes with increased efficiency, productivity, and timeliness. The HIM department has been able to contribute to the success of the referral process, which has seen an increase in the number of patient referrals as well as improved provider and patient satisfaction.

Best Practices and Lessons Learned

There is no right answer or "best" method of implementing health IT into an organization. It ultimately is up to the organization to commit to advancing technology not only for creating efficient and effective internal operations, but also to improve the overall quality of patient care. HIM professionals must sit at the table and be involved with all planning sessions-since it is the HIM professional's expertise and understanding of the legal health record that ensures a well-designed EHR.

UWHC HIM officials recommend that other HIM professionals shouldn't feel intimidated by health IT opportunities, but see technological change as a worthy challenge. They should ask questions and stay current with the EHR implementation plan to make sure it is following its intended purpose and timeline.

Moving to an EHR creates a paradigm shift for all parts of a healthcare organization-especially the HIM department. The initial focus of UWHC's EHR implementation, appropriately, was on the physicians' and other care team members'

documentation needs. However, the design of the EHR eventually shifted to the information technology staff that were trained to manipulate the software to create the EHR. The HIM department at UWHC struggled to shed the image as "keepers of the paper record" and to transfer their knowledge and experience from the paper world to an electronic one. But the department evolved over time, and continues to expand their value in the electronic world. Change is now a constant state, UWHC officials say, and making sure all staff continues to grow and broaden their skill set into the electronic health record department of the future is a priority at the facility. One major lesson UWHC has come to understand is that although an EHR cannot solve all the problems that exist in a paper world-and in fact can create some new ones-an EHR does tremendously streamline workflow and improve efficiency overall.

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