Practice Toolkit: EHR Implementation

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The Billings Area Indian Health Service (IHS) began implementing an electronic health record (EHR) about three years ago, beginning with the Crow Acute Care Hospital and its Wind River outpatient clinics. This article outlines the steps the organization took to reach "go live."

Pre-implementation

First, the governing body and executive leadership and management teams had to agree that the EHR was worthy of the required resources. This required consultation with tribal councils, patients, staff, and other customers about the proposed EHR implementation and its effect on patients. IHS anticipated increased wait times in clinic settings while providers learned to use the EHR. The organization also recognized that IT staff had to be readily available to assist EHR users.

Once it was determined to go ahead with the implementation, IHS had to decide whether to implement the EHR in inpatient settings, outpatient settings, or both. Likewise, implementation planning was needed for dental, public health nursing, optometry, lab, x-ray, and order entry services. IHS realized that implementation planning had to be site specific, recognizing that what worked for one site might not work for another.

Decisions also had to be made about the need for additional desktops, laptops, or tablet PCs and whether the system would be wireless or remote. This required an evaluation of the routers, servers, switches, telephone lines, computers, printers, power protection devices, space, and wiring. Privacy issues and patient flow were also evaluated.

IHS assigned an EHR team with representatives from all services, including managers, HIM, clinicians, ancillary departments, and IT. The team met at least weekly, with the mission of creating EHR ownership.

Implementation and Training

A number of EHR training sessions were provided before implementation, including demonstrations and hands-on sessions. IHS found that using knowledgeable trainers and providing one-on-one training was extremely effective. The organization also loaded the EHR test system on users' workstations, allowing them to practice using the EHR. A competency checklist was used to document each user's abilities or ongoing training needs.

The project plan noted significant milestones with respect to training, hardware acquisition, and use of the EHR system. Regardless of how small the step, IHS made a point to celebrate and recognize those who made the EHR a reality. A weekly newsletter was created to communicate EHR progress and successes.

Other Key Implementation Tasks

Files were set up for new users, hospital locations, and providers, which will be monitored routinely. User class, document class, title, laboratory, radiology, and medication files required clean-up and set-up, and pick lists for procedure and diagnosis codes were created.

Quick orders for pharmacy, laboratory, radiology, and nursing were created and set up for provider efficiency. Business rules for verbal orders, check-in procedures, queues, laboratory results, pulling charts, and printing and filing chart copies also were outlined.

IHS decided to base EHR viewing, editing, and creating template privileges on policy, not individual wants and desires. Some note templates were available from the Veterans Administration EHR system, VistA. At each facility, the template specialist

played a key role in the overall EHR implementation. Personalized provider templates were discouraged in favor of service or specialty-related templates.

EHR users set up personal preferences for progress note titles, creating personal patient lists, preferred screen views, and establishing clinical teams to communicate vital information. Notifications were set up to alert EHR users about unsigned notes or orders, so they could be completed in a timely manner. Surrogates were assigned for vacations or other times when someone else needed to monitor a provider's patients and take over other duties.

New Processes

IHS then determined when to discontinue pulling the paper chart for clinic visits as well as what to file in the paper chart and what to scan into the EHR. The release of information process was also reviewed. New processes were developed for handling incorrect entries and conducting HIM quality assurance activities.

New processes were needed for coding diagnoses, procedures, and services rendered. IHS also had to decide whether providers would code diagnoses, procedures, supplies, and services with coding staff verifying accuracy in the EHR setting or whether coders would code the visit based on the provider's documentation. Process revisions were necessary to alert HIM staff of any deficient entries not completed in the EHR. The organization also had to determine how to handle duplicate visits and wrong patient and wrong chart situations.

Going Live

One of the final items on the project plan included validating that the live system had been loaded and fully tested. We verified computer availability and made sure that printers were working and ready to roll. IHS checked the availability of recharging equipment for portable units. We verified there were sufficient stands, carts, space, and that privacy issues had been addressed.

Appropriate scheduling adjustments were made with patients and providers in anticipation of the user's learning curve for the system. A back-up plan was also in place in case the EHR failed.

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