

# UW MEDICAL CENTER ELECTRONIC HEALTH RECORD BENEFITS & CHALLENGES

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# Choosing the System



- One size fits all approach
- System to meet specific needs
  - ▣ Specialty areas (GI Endoscopy, Cardiothoracic Surgery)
  - ▣ Interfacing
- How will future system requests be handled

# Executive Endorsement



- Hospital Administration
- Physician Leadership
- Key Stakeholders
- Structure of Accountability
  - ▣ IT oversight

# What's the Message?



- Agree on the message
  - Optional
  - Mandatory
- Message should be consistent across all Executive levels

# Implementation & Training



- Do not underestimate complexity
- Training is essential & critical to success
  - ▣ Physician Support
- Take the time to do it right

# Current System Overview



- Cerner (Inpatient & some Outpatient)
- EpicCare (Family Med Clinic, Eastside Specialties, Ortho & Sports Med Clinic)
- Ancillary systems for various specialty areas (ie; Docusys, McKesson, GI Endo)

# Impact to HIM



- Changing workflows from paper to electronic
  - Assembly of paper record no longer necessary
  - Analyzing record for deficiencies occurs after record is scanned
  - Automated workflow for deficiency identification in EMR
  - Coding staff access records electronically to assign ICD9 codes and final bill the records
  - Coding staff can access documentation remotely
  - Fileroom staff workflow shifting from sorting & filing loose papers to prepping & scanning records into EMR
  - Record movement has decreased from 38K to 7K in 12 months
  - Loose paper filing decreased from 2000 inches to 300 inches

# Impact to HIM



- Changing skill sets
  - Staff that never worked with computers in the paper environment are having to learn technical skills
  - Job classifications are changing (Tech 1 work is now Tech 2 work with more technical skills needed)
- Forms & Mapping
  - Bar-codes on forms are a must, avoid manual indexing
  - Rogue and pirated forms have to be fixed
  - Mapping of forms is essential, avoid creating too many categories
  - Locating a paper based document for a long hospitalization

# Impact to HIM



- **Training**
  - Staff training is essential, from the coding staff to the release of information staff, they need to know how to navigate through the scanned record
  - If settings aren't understood, a user can easily miss documentation
  - DOH and visit review of records
- **Communication**
  - HIM staff need to know when changes are made to the EMR
  - During scanning roll-out changes occur weekly, communicating the location of documentation to direct care Providers is challenging
  - Look in EMR first and then order paper record

# Impact to HIM



- Scanning or Direct Entry
  - Decrease dictation and move to direct entry
  - Dragon speech recognition, Hot Spot Dictation additional tools for Physicians
  - Pitfalls of Direct Entry are “canned reports” which can be a compliance concern, spelling and terminology along with the use of unacceptable abbreviations
  - Scanning paper currently occurs “after” discharge or after the clinic visit so documentation isn’t available immediately, direct entry is available immediately
  - Some Physicians using direct entry are experiencing time savings in reviewing & editing their e-sign queue

# Impact to HIM



- **Metrics to measure success**
  - Efficiencies gained by Dept (ie; decreased chart pulls, A/R days decreased due to faster coding, decrease in transcription)
  - Physician satisfaction
  - Patient satisfaction (patient portal)
  - Documentation for compliance & quality measures ie; Core Measures, post op antibiotics, pneumovax immunization with direct entry templates, capture data consistently through use of templates

# Impact to HIM



- **A New Set of Challenges**
  - Fix file, 5 FTEs that manage the fix file queue
  - Getting documentation “filed” into the right encounter (EPIC label issues)
  - Actual date/time of care provided if documented later (RN documentation and OBSV hours)
- **Retention**
  - Retention of the records both in paper and electronic media needs to be addressed
  - UWMC has a unique situation in that the State of WA has to certify the electronic system before we can destroy paper records that have been scanned
- **Defining the Legal Medical Record**



Questions?