Documenting Practice Workflows and Envisioning the Future

The many and varying clinical and administrative processes, workflows and documents that currently drive and control the daily lives of individuals within a practice make a perfect starting point for planning the future and identifying the specific requirements the "ideal" Electronic Health Record (EHR) system will need to effectively support the goals of the practice. While, on the surface, it may seem logical that members of your EHR selection or implementation teams already understand how the practice currently operates, when workflows and processes are explored at a deeper level, many interesting discoveries are often made. When was the last time anyone in the practice had an opportunity to take and objective look at all the processes, interactions and paper that drive your daily practice? This is the time to do so.

Taking the time to revisit and document current workflows within the practice before moving forward with an EHR selection and implementation will greatly benefit the practice. These benefits will include:

❑ Streamlined processes, even before automation.
❑ More complete understanding of specific requirements the new EHR system will need to be able to support.
❑ Practice-wide participation in evaluation and "new thinking" that will fuel the enthusiasm and ideas for EHR system success.

The following tips will help you ensure that all key workflows are effectively addressed and thoroughly considered in defining your EHR system requirements and in planning your future practice environment enabled by automation.

1. Involve All Areas of Practice

Understanding the specific details of exactly how the practice currently functions is critical to understanding all of the requirements an automated system will need in order to streamline and support these functions. The outcomes of the various workflow processes (e.g., the completed form, the consultants report) may be well understood by practice leaders; however, the detailed procedures, triggers, short-cuts, etc. that personnel use along the way to produce these outcomes are often far less understood. Individuals closest to the workflow process will have the greatest understanding of their needs and are valuable resources for evaluating the current workflow processes and understanding the future needs.

A simple way to identify the specific individuals whose involvement is needed for obtaining a comprehensive view and understanding of any current workflow is to identify the staff involved in the various points of patient interaction and/or medical record maintenance for that process. Individuals involved in today's processes will be impacted by the automated processes of the future. Getting their input and involvement in workflow analysis will help to assure the selection team has a full perspective of needs and impacts when making the EHR system choice. Involving these individuals will also help ensure understanding of what the practice is working to accomplish with the EHR system and promote "buy-in" across all areas of the practice for its success.

2. Look with an Open Mind and an Objective Eye

It is exciting to begin planning the automated future. However, before jumping ahead with this planning effort, it is both wise and informative to take an objective look at all that is included in the current manual processes and documents. The team will want to determine what parts of these

really should be automated and what parts no longer makes sense and should be eliminated, even before a new EHR system has been implemented.

As the team involves and listens to the individuals who currently support the practice's paper-based processes, it is important that they do so with an open mind toward change and a critical eye toward opportunities to streamline processes, eliminate steps from the workflow and eliminate or consolidate forms and paper documents. Those involved in the workflow documentation efforts need to avoid defensiveness over current ways and should be encouraged to "think outside the box" and question "why". This is the time to revisit why "it has always been done this way" and find new ways for moving forward.

3. Document the Current Workflows

An excellent way to acquire needed information about a work process is to have one or more members of the selection team, with paper and pencil in hand, walk through the process as if they were the patient and/or the paper medical chart. They will want to assess:

❑ Who is involved at each step in the process?
❑ What do they do that has impact on the overall process?
❑ What do they add to the chart?
❑ What do they use from the chart?

Along the way, it is important that they analyze the documentation tools (e.g., forms, labels, tags, etc.) used by the various staff members use and ask the "what if" questions, i.e., what would be needed within the EHR system to replace this tool, form, paper chart and manual processes?

Although formal documents created by special flow charting software tools are impressive and nice to have available, the understanding gained from documenting the processes is far more valuable than the documents themselves. It is more important to accurately gather information in a format that all parties of the selection team, and the future the implementation team, can read and understand. Simple hand drawings and descriptions are sufficient if they capture the necessary detailed information.

A workflow description needs to clearly address who does what and the hand-off processes between departments/areas (e.g., reception to nursing, nursing to physician, physician back to nursing, nursing to lab, etc.). As team members walk through the many clinical and operational tasks that make up the day-to-day activities of the practice, they need to take careful note of critical information, triggers, flags, etc. that are included in paper documents and/or operational tools. In general, each workflow document should minimally touch on these points:

❑ How does the practice communicate internally about the steps of this process?
❑ What information from this process needs to be communicated externally and how is this achieved?
❑ Who touches the chart and why (e.g., updates, referencing only, copying and forwarding, etc.)?
❑ How do we know the process is complete or needs further follow up?
❑ Who tracks this, and who follows up?

Common activities and tasks to include in documenting your current workflow processes are:

❑ Routine Visits (from the point of check-in to completion of the visit)
❑ History and Physicals
❑ Urgent/Same Day Visits

- ❑ Walk-in Patients
- ❑ Emergency Patients (both within the office and at emergency rooms)
- ❑ Routine Patient Telephone Calls
- ❑ Emergency Patient Telephone Calls
- ❑ Prescription Orders
- ❑ Prescription Refills
- ❑ Laboratory Orders
- ❑ Radiology Orders
- ❑ Back Office Orders
- ❑ Referral Requests
- ❑ Documentation Requiring Physician Sign-off
- ❑ Nurse Only Visits
- ❑ Patient No Shows with Provider Follow Up
- ❑ Results Reporting and Patient Follow Up-Non Critical
- ❑ Results Reporting and Patient Follow Up-Critical
- ❑ Chronic Care Service Tracking and Recall
- ❑ Preventative Health Tracking (e.g., Mammograms, Pap Smears, etc.)
- ❑ Disease Collaborative Reporting
- ❑ Compliance Reporting

4. Gather Forms, Logs, Stickers and Stamps

During the assessment and documentation of existing practice workflows and processes, it is very useful to collect and assemble a thorough inventory of all chart forms, stickers, stamps, logs and other documentation tools that the practice currently uses to collect, record, access and communicate information. Examples include history and physical forms, pediatric well-child check forms, pre-surgery history and physical forms, and medication administration stamps. If there are forms the practice uses to report to State or Federal agencies, disease or special study collaboratives or other outside entities that contain clinical information, these forms should be gathered as well.

Again, it is important to objectively evaluate each of these documents. Since in most practices, forms and documents have been developed over a period of time for different purposes and to support varying manual or data entry processes, there is typically a significant degree of overlap, redundancy and obsolete questions/ information included in the forms and documents that can be cleaned up or eliminated before considering automating the information. Critical evaluation will help determine whether forms and documents should be considered for conversion to an electronic format and/or consolidated with other forms and tools. Because these current tools are what the practice relies on in order to conduct and document patient visits, they are the ideal starting point from which to develop a list of required data, templates and features for the EHR system. Understanding the full use of these tools now will also provide the framework for future EHR implementation planning and system configuration.

5. Envision Paperless Workflows

Using the overall goals for an EHR system implementation as a guideline, it is an exciting and extremely valuable exercise for EHR Selection Team members to spend time "envisioning" how the practice could work with an absence of paper charts, forms, and manual processes – with current efforts replaced, or supplemented by, efficient automation, easy access to data, etc.

When envisioning EHR system use and redesigning work processes, it is necessary for the team to imagine the permanent disappearance of paper medical charts from the practice. Carefully thinking through and planning how, ideally, each task within the practice could be accomplished using an EHR system helps to identify optimal organization and flow of screens, needed template content, output formats, interfaces, alerts and external access requirements. Using the documents and descriptions of current workflows and processes as a starting point, the team can begin examining the specific steps and tools that can be automated by an EHR system and identify specific capabilities the EHR system needs to make the automation easy and logical to use.

A good way to start envisioning and brainstorming possibilities for automation support is by having the individuals involved in the current paper-based processes complete the following sentence -- "I could do my job far better/easier/faster if…..".

Common responses to start off this effort might include:
- …I could view this result on line.
- …I could see a graph of my patients laboratory results corresponding with the specific medications prescribed.
- …I knew if the patient had shown up for their test before scheduling the follow up visit.
- …I didn't have to complete this log every day.
- …the system would tell me which patients have asthma and the last time they were seen within the practice.
- …I didn't have to call the pharmacy every time a refill was approved.
- …the system could automatically tell me how many milligrams of Amoxicillin I should give my pediatric patient.
- …I could access the patient medical record information from the hospital.
- …I could see a summary of the clinical information related to my patient's current pregnancy only
- …I could easily read the medical record when completing quality assurance audits.
- …I could email directly to the specialist and attach specific information from the chart in a secure manner.
- …I didn't have to reenter all this information into the disease registry.

6. Rethink Reporting Options and Opportunities

Since reporting is extremely difficult to accomplish from data included in paper charts and processes, many practices have learned to live without trending, outcome and other reports that would allow them to provide better, more efficient or more complete care to their patients. Reporting in a paper-based practice is often limited to basic information or the requirements necessary to meet insurance or regulatory compliance. These reports often involve heroic and arduous manual tallying, copying and re-entry of data into spreadsheets to prepare.

These efforts, however, are not constraints with an automated EHR system. While rethinking workflows and processes and planning for the future, it is an ideal time to also rethink reporting opportunities in a whole new, automated light. Now is the time to revisit all the information your practice wishes it could have available to understand the overall health status of its patient population and proactively plan care.

It is important to keep in mind that reports need not be limited to printouts. Automation allows electronic reports, graphs, action lists, etc. that can provide high-level summaries across the patient population and "drill-down" detail to individuals to help the practice better understand and manage patient care needs.

7. Create New Documents and Workflows in Anticipation of an EHR

While preparing for the selection and ultimate implementation of an EHR system, there are often many immediate, interim steps that a practice can take to both improve current processes as well as ease future EHR transition. These interim steps typically include any or all of the following:

- ❑ Standardizing common terminology and coding across clinicians (e.g., medication lists, problem lists, medical and surgical history).
- ❑ Standardizing practice methodology and documentation across clinicians (e.g., assessments to be included for age-specific physicals, best practice for asthma care, points of education for patients with congestive heart failure, chronic pain scale and assessment, assessments to be included for a cognitive evaluation).
- ❑ Developing and implementing paper-based templates for documenting specific treatments in a consistent manner (e.g., a documentation template addressing Otitis Media where the template might include all portions of the SOAP [Subjective, Objective, Assessment and Plan] note).

These standardization and template design activities will be critical for effective EHR implementation. They, however, can also yield excellent interim gains for the practice, before implementation occurs, in terms of clinical and operational efficiency.

8. Use the "Envisioned" Workflows to Develop Practice Requirements

All of the information gained during the above workflow and envisioning steps should serve as the basis for the EHR system requirements for your practice. It is critical to document these and carefully compare each of the requirements to the various vendor product capabilities, flows and formats during demonstrations and reference checking activities. The goal is to find the vendor system that most closely supports the ideal future practice that the team has envisioned.

9. Be Open to New Workflows

The phrase "there's more than one way to skin a cat" definitely holds true with EHR workflows. The EHR system vendors all have a "typical" workflow process for each of the common processes within a practice. As your practice moves through the EHR evaluation and selection process, it is important to keep an eye on the ideal processes and workflows that you have envisioned while also remaining open to other process and workflow options available within the specific EHR system being evaluated. Holding too rigidly to specific workflow details for the new system may cause your practice to miss out on other opportunities or options for streamlining and enhancing quality of care and services. Finding the right balance for your practice is a definite challenge, but will prove well worth the effort over time.

While you can expect to revisit and revise a number of these envisioned workflows and processes as you gain greater knowledge and experience with the EHR system during implementation planning, by completing the above steps during the evaluation and selection process, you will be assured of making a far more informed and confident decision. You will also understand far more about your current practice environment to help you greatly streamline your implementation process.