Integrating Electronic Documentation Across Pediatric Institutions

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Introduction
The use of electronic health records is a growing demand nationally. The HITECH Act laid the groundwork for the adoption of EHRs by the year 2015. Augmenting the requirement of adoption, the Affordable Care Act has also set guidelines for meaningful data to be entered into the EHR based on national standards. Although institutions are required to implement EHRs, the reality is that different organizations have the authority to implement a system of their choice that meets not only the federal demands of documentation, but also the strategic demands of the institution. In today's complex healthcare environment, multiple healthcare organizations must often collaborate in patient care delivery. This poster will highlight the collaborative work needed to standardize the documentation of patient care from three institutions into one EHR. The three institutions included an urban pediatric hospital, an urban adult hospital, and an urban cancer institution. Using a variety of EHRs during the continuum of care for a single patient seen at each of these settings was not transparent to all institutions. The pediatric institution's EHR, already used by two out of the three institutions, was selected as the sole EHR for this project.

Methods
Over a three month period, a multidisciplinary working group was tasked with instituting a single source of documentation in the pediatric institution's EHR. This effort required identification of documentation needs of all providers associated with the care of the radiation oncology patient. Patient care delivery included radiation, medication administration, and chemotherapy delivery. The analysis included the need to recognize the various billing processes related to medication ordering and distribution and the radiation therapy. Clinicians involved in the documentation process included radiation oncology doctors, radiation oncology nurses, radiation oncology radiation therapists, pediatric oncology doctors, pharmacists, and ancillary clinicians requiring view only access. The implementation plan included the engagement of stakeholders, analysis of workflow, identification of the documentation needed, documentation building and testing, as well as clinician training and support. The analysis of billing was simplified as the charges were already captured in other workflows, and therefore this new encounter build dropped all charges. Already existing discrete data fields were used to ensure standardization and consistency. Meaningful use demands were also considered.

Results
Meeting a strict go-live date, the implementation of the EHR in the urban adult hospital was successful, as demonstrated by patient encounters appropriately displaying in the designated EHR which allowed for clinician documentation. On an ongoing basis, clinician support is provided to improve the capture of details of documentation, as well as to be able to identify documentation needs. A nursing informatics specialist continues to meet with the nursing staff on a weekly basis to identify needs and provide supplemental training as requested by users.

Discussion/Conclusion
As a result of the project implementation, documentation completed throughout the care of the pediatric radiation oncology patient is transparent to all of the caregivers throughout these three institutions. Anecdotal feedback from all caregivers is that the collaborative process for documentation allows for more integrated care for this complex patient population.

Reference:

1. Patterson, E., Zhang, J., Abbott, P., Gibbons, M., Lowry, S., Quinn, M., & ... Brick, D. (2013). Enhancing electronic health record usability in pediatric patient care: a scenario-based approach. Joint Commission Journal On Quality And Patient Safety / Joint Commission Resources, 39(3), 129-135.