South Island MSA

IHealth | island health

Frequently Asked Questions (FAQs) on IHealth Electronic Clinical Documentation

Members of the South Island Medical Staff Association (MSA) have varying degrees of clarity about the current IHealth status, expectations, and rollout plans. This FAQ reflects discussions among members of the Medical Staff and at the South Island MSA IHealth Committee.

Brief context for each theme is provided in italics.

General Concepts

While most physicians are comfortable with the concept and use of Electronic Medical Records, or EMRs, in community medical offices, the broad concept and application of an Electronic Health Record (EHR) is not as well known.

1. What are the effects of an EHR on a) patient care and patient outcomes, and b) physician workload?

Patient outcomes:

- **Decreased medication errors** thanks to computerized provider order entry (CPOE), clinical decision support, and a number of safety tools related to medication management.
- Improved and timely **transitions of care** through electronic clinical documentation (ClinDoc).
- Efficient and **standardized charting** practices (i.e. for allergies and problem lists: document once, validate, then re-use) improve care.
- **Surveillance**, as an automated early warning system that alerts care teams to patients who deteriorating (e.g. Pediatric Early Warning System or PEWS).

Physician workload:

- Evidence indicates there are a range of users – some who become more efficient than when they transcribed or hand-wrote notes, others that remain the same, and a few who find that electronic tools are more challenging to use.
- Efficient users report that their use becomes more sophisticated with time, they use the tools as designed, and they become expert in the use of autotext, favourites, and standardized templates.

2. What improvements were made to the platform since the Nanaimo rollout? How will these changes impact the subsequent rollout?

The South Island rollout will mirror the latest Clinical Documentation workflow optimized at Nanaimo Regional General Hospital (NRGH) over the past five years.

Numerous changes to software, hardware and network architecture include the following:

- An updated Dragon dictation application with introduction of a mobile phone app
- Increased flexibility using Summary Pages with the ability for physicians to rearrange and customize components
- Improved system reliability through enhancements to wireless and IT infrastructure
- Improved visibility of pharmacist documentation within physician workflow
- Active notification of deceased patient chart entry
- Clinical Order set changes, which are more modular and streamlined
- Medication display lines changed to improve readability

Many improvements have been made – and alterations are ongoing – to achieve a tailored, supportive, and stable EHR. An Island-wide approach to sharing experience and propose enhancements to improve the EHR experience will continue as the change happens, through clinical working groups involving medical and clinical leaders. Providing various types of support for all groups using the EHR is a priority.

3. How can front-line physicians access support and easily find answers to questions they might have?

As of June 14, 2021, there will be expanded Medical Staff support at Royal Jubilee Hospital (RJH) and Victoria General Hospital (VGH).

To support the success of this implementation, direct support from the IHealth Team (Provider Education and Experience, Clinical Informatics, and Physician Peer Mentors) will continue to be on-site and rounding 08:00 to 16:00 Monday-Friday.

Additionally, the **IHealth Team can now be contacted for on-site dispatch or virtual support through the IHealth Central Support Desk at 1.877.755.7001**.

Clinical Documentation Support	IHealth Central Support Desk (On-site dispatch or virtual)
Hours	**08:00 to 16:00 Monday-Friday**
Contact number	**1.877.755.7001**

After Hours and Weekend Support

- Contact the Clinical Service Desk at **1.877.563.3152** or **18777.**

Self-Serve Support

- You can also check **eCoach,** which is available on the banner bar in PowerChart and includes standard Cerner documents along with Island Health specific videos and functionality content.

As we move towards go-live at RJH on September 20, 2021 and VGH on October 4, 2021, support will be increased.

4. Who do I contact for broader questions about Templates, Equipment, Training, etc.?

- Contact your **IHealth Site Physician Lead** for Medical Staff questions regarding education, or to pass along ideas or feedback.
  - **Royal Jubilee Hospital (RJH):** Dr Pooya.Kazemi@viha.ca
  - **Victoria General Hospital (VGH):** Dr Kellie.Whitehill@viha.ca
- Dr Eric.Shafonsky@viha.ca, Associate Chief Medical Information Officer, is also available to answer questions and connect you to the appropriate resource.
- Contact your **Clinical Informatics Lead for your specialty** for **template** questions.
  - If you are unaware who your lead is, please contact Kristina.Mcdonald@viha.ca
- **IHealth Medical Specialty Leads** are another way to be involved, and current postings for IHealth Physician Department, Division and Subspecialty Leads are accessible here.

Electronic Clinical Documentation

1. Physicians have heard that IHealth is coming, but what is 'ClinDoc' exactly?

Electronic Clinical Documentation, aka 'ClinDoc', comprises the components that make up the documentation of clinical care. We have combined the documentation of care processes with specific views and functions to support that documentation. ClinDoc includes:

- **Workflow**
  - **Provider View** (feature within the Cerner EHR) – enables physicians to complete different types of notes (admission, progress, discharge, operative report, etc.) through use of different tabs that can be catered to suit workflow needs (consult, rounding, discharging, ambulatory clinics). Provider View allows **simultaneous chart review and documentation** to update the patient record in one place.
  - **Message Center** – **electronic inbox** that receives and organizes any documentation requiring the physician's attention. This tool sorts your documents for ease of use and **prioritization**, and offers users the ability to **sign documentation**.
  - **Problem List** and standard note types
  - **Patient Lists**
- **Voice Recognition**
  - Dragon Dictation – voice recognition software to capture information in the EHR.
- **Medication Reconciliation**
  - A standardized approach to review, confirm or modify a patient's medications in a systematic way as patients' clinical conditions change and patients go through transitions in their care.

2. Divisions have been given dates for when they are being "rolled out", what does that actually mean?

"Rollout" is a term often used to describe the period when a new tool, technology or process change is implemented, specifically when **users start using that tool, technology or process daily** in the work setting. During this time, **extra supports are available** to help with the transition.

3. What is the rationale for rolling out Electronic Clinical Documentation and CPOE separately?

Following the NRGH implementation, multiple reviews were completed, including by Dr. Cochrane and by Ernst & Young. There was extensive input from the physicians and staff at NRGH. Ernst & Young **recommended a phased approach** to the future implementations. The intent was **to decrease the change impact** through partial introduction of the system.

The **advantages** of this approach:

- Physicians can provide feedback on each component;
- Physicians can identify the most important/useful capabilities of each component;
- Physician needs and supports are better managed.

The **disadvantages** of this approach:

- Takes longer to fully implement the Electronic Health Record;
- Workflow is hybrid (Orders on paper while documentation is electronic) for a period;
- Re-learning will be required when CPOE goes live because of the integration of documentation and ordering processes.

Hardware Issues

Especially at VGH, physical space and workstations are already at a premium. Physicians are concerned that an increased amount of computer time required for their clinical documenting work could impact them seeing patients, or that they will have to spend time looking for a computer to use.

1. **How many extra computers/workstations will be available, and where will they be located? We understand that a needs study was done to determine this number, is that available? Are the newly installed devices for physicians only?**

    - Clinical teams have worked with the site Medical Staff and have determined what needs to be ordered and where spaces require modification to support more workstations being installed.
    - Device availability will be monitored regularly throughout the activation, and further devices will be added if required.
    - The devices identified and installed for physicians are dedicated for physicians' use.

2. **Will we be able to use our own computers and tablets? Will the current WiFi be able to handle the increased load, or will it be upgraded?**

    - Network assessments have been completed and indicate no capacity issues.
    - While you can use your own devices, this has not been needed in the past. We are planning to bring iPads into our device mix with a compatible version of PowerChart. This requires new cloud-based technologies, and will be discussed with Clinical and Medical teams as it becomes available.

3. **A card-based system exists to sign into a workstation. Will this be available?**

    - The **"Tap and Go" (Imprivata)** solution is used at NRGH and in a few Primary Care centres. Evaluation of the NRGH pilots is underway.
    - Tap and Go will be used in some areas that show it to be critical to the workflow, e.g. in Labour and Delivery at VGH.
    - **Demonstrations** of "Tap and Go" can be arranged, and can be installed if valuable. Due to initial and ongoing costs, this is subject to appropriate benefit.

Training

To relieve immediate pressure on clinical operations, the implementation of ClinDoc for Nursing and Allied Health groups at RJH and VGH have been rescheduled to September/October 2021, respectively. How will this impact training and rollout for physicians?

1. **When will ClinDoc training take place for each wave? When will the various training modules be available?**

    Medical Staff training is well underway, with training modules available on the learning hub for Medical Staff to complete as their schedule allows. Education will continue along the originally scheduled "wave" timing for all Medical Staff. **The expectation is that all Medical Staff will be trained prior to the full activation of ClinDoc starting in September 2021.**

As Medical Staff become educated according to the wave schedule, they will be able to use the front-end voice recognition dictation and related tools to complete the notes that they currently dictate (admission histories, consultations, operative/procedural notes, and discharge summaries). **In September will progress notes will be added.**

2. **Four hours has been allotted for ClinDoc training. Does that include the time necessary to set up templates and training on Dragon Dictate?**

   Yes, Dragon Medical One education is a pre-requisite for physicians, midwives, nurse practitioners and medical learners.

3. **If individuals need more than four hours of training, will additional funding be available?**

   Island Health has based its education remuneration on learnings from the Lower Mainland. **A total of 10 hours of education will be funded,** with **4 hours for clinical documentation** and **6 hours for CPOE.** In addition, we are looking to provide education credits.

4. **Will funding be available to Departments/Divisions to develop discipline-specific templates for Clinical Documentation?**

   Funding is available for design work of Island-wide templates and order sets.

5. **My group does call on a weekly basis. What supports will be available for those who are not working in hospital during the designated onboarding period?**

   All divisions/departments have allocated times for education. New physicians will be educated as they join Island Health. Support will always be available through the service desk. If there is a specific need for individuals to have elbow-to-elbow support, please contact the clinical informatics specialist for your specialty group.

6. **Will education sessions be available outside of regular working hours – say, for evenings and weekends?**

   Currently, education and skill sharpeners are available Monday through Friday, 07:30 to 16:30. We are monitoring participation to adapt the schedule, if necessary. We realize that there may be individuals who are unable to accommodate this schedule and we will make support available. During "go-live", support teams are available every day.

7. **I am in Internal Medicine – scheduled for third wave – but consult on patients on Rehabilitation wards – scheduled for first wave. Will I be able to continue to use paper progress notes on rehabilitation wards until I am on-boarded?**

   Progress notes stay on paper until the end of September.

8. **Will transcription still be available, to help buffer the transition? For how long? Can I use transcription for everyday progress notes until I feel comfortable with Electronic Clinical Documentation?**

   Transcription Services will continue to be available.

9. Will Autotext be taught as part of the ClinDoc training?

Yes, Autotext will be incorporated into the skill sharpener sessions, as well as in the Virtual Engagement Lab.

System use/Personalization

As is often the case, physicians are discussing successes and challenges that groups who are further along in IHealth implementation are facing.

1. **Some groups have reported that template development is taking a long time, especially for groups where a few people are doing the work for everyone. How can this be compensated? Will there be funding for development of CPOE Order Sets? If yes, and there is excess, can this be used to compensate ClinDoc template development?**

    - Order Sets are being developed by an IHealth CPOE Lead, as well as with our provider working groups (which would be compensated).
    - In May 2021, there will be postings for Island-wide Medical Specialty Leads, who work with Clinical Informatics Leads to develop Island-wide templates.
    - Template optimization is an ongoing activity. It's important that basic functionality is introduced and supported before moving on to more complex functionality.

2. **Some have reported frustration with the Problem List. Why should it be used instead of free text?**

    When information is entered into the Problem List, it flows automatically into the patient note. Changes or modifications are instant and follow the patient. Physicians save time by not having to hunt through previously published documents in search of one to copy.

    Having reviewed dictated or free text notes, we know that the same patient, across multiple documents, can have inconsistencies in terms of reported problems or diagnoses. Committing to a single source of truth contributes to improved documentation.

    Some Lower Mainland colleagues report using Problem List very well, saving time with repetitive dictations across different team members or admissions.

Workload

With an already heavy clinical workload, there is concern that implementing IHealth will increase pressures on physicians.

1. **Which areas will get supernumeraries? How were these areas selected?**

    Supernumerary support is normally utilized during a full implementation that includes CPOE. However, we have allocated some supernumerary time for ClinDoc based on high demand specialties (i.e. hospitalists). This can be reallocated though Local Medical Advisory Committees or through conversations with your Site Medical Director and IHealth Physician Site Lead.

2. **What workload supports will be available for those areas without supernumeraries?**

    Because this is considered a "soft launch" and dictation is still available over the summer months, it is anticipated physicians will gain competency gradually, and will revert to dictation should they need to

on a particularly busy day. Our provider education team, clinical informatics, project, and physician peer mentor teams will support during the wave activations.

3. **We understand reducing bed capacity is not considered feasible. Are there other ways that workload can be reduced?**

   Standard reductions are typically used during combined ClinDoc and CPOE activations. Supernumerary physicians, dictation/transcription services, and adjusted scheduling of ambulatory clinics can support this. The experience of our Emergency Room colleagues is that there was no need to reduce ER visits to learn how to use Electronic Clinical Documentation tools.

4. **Will there be a pause in the Surgical Renewal program during implementation?**

   At this time, there is no change planned for the Surgical Renewal program.

5. **It is thought that supernumeraries may not be needed for ClinDoc rollout? Can the funding for these be put towards additional supernumeraries for CPOE instead?**

   Supernumerary funding is operational funding and is year specific. It can be used to support ongoing education requirements, for example, or to add more peer mentor support. Decisions related to this funding are made through the site Medical Leads. There is flexibility in how each identified group might use available funding for this purpose.

6. **There is concern about increased cognitive load during rollout. What activities or actions are planned to mitigate this?**

   IHealth Exec Steering Committee and GEO 4 leadership decided in April to re-schedule Nursing and Allied Health groups to September/October, in response to staffing pressures across the system. Medical Staff have encouraged to continue their education and training and put that into practice, with supports available, leading up to full RJH and VGH "go live" in September/October. Further suggestions are appreciated about additional Medical Staff supports.

Culture

Physicians would like to be not just informed about what is going on, but also to be involved in decisions being made about their workplace. Some have worked in other regions and have significant experience with other EHRs.

1. **What measures are you taking to ensure that the implementation process is transparent?**

   Medical Directors, the Executive Medical Director, and Medical Leads ensure that their teams are engaged, heard, and prepared. They will oversee final go/no-go decisions. Readiness is monitored through surveys, discussions, and data sharing with clinical teams.

   The IHealth Site Physician Leads will support communication, engagement and transparency of process for the Medical Staff.

2. How are you going to engage front-line physicians in implementation and ensure that theyhave a voice in the process?

IHealth Site Physician Leads will engage with front-line physicians. Learnings from previous activations have been incorporated and include improvements to engagement, communications, governance, and decision-making. Teams are clinically led, are listening carefully, and are adjusting course as required when issues arise. IHealth is also working closely with colleagues in Medical and Academic Affairs and Provider Education and Experience, and maintains regular dialogue with Medical Staff Associations. Interdisciplinary workflow review sessions and joint problem solving also support this approach.

For more information, contact IHealth Specialty Division Leads to get involved, or apply for one of the IHealth Physician Lead postings accessible here.