Sample Answer to Workflow Analysis Assignment

Workflow Analysis of a Primary Care Clinic
Before and After Implementation of an Electronic Health Record

There are numerous ways in which using information technology could improve the workflow process and improve patient satisfaction and outcomes at the Primary Care Clinic with a paper medical record.

Information technology exists that allows patients to schedule appointments with providers online. This allows for the patient to have more flexibility as to when they choose to schedule an appointment. For example, a patient may experience a sore throat on a Sunday evening. With online scheduling, the patient may be able to schedule an appointment at his or her clinic for the following day. This eliminates the need for the patient to personally speak to a receptionist during business hours. In addition to appointment setting, there are several applications in which patients can engage their health record from the internet in order to manage chronic illnesses, gain an increased understanding of their health status and develop support systems.

An electronic health record (EHR) allows for patient information to be stored and viewed in one place. As Seckman notes, the EHR, “provides better and faster access to patient care information,” (2014, p. 97). In an EHR, all clinical information is stored in a central database. If needed, records that are not initially input as data are scanned into the patient’s chart and accessible via the computer workstation. When this clinic utilizes EHR, it will eliminate the need for a person to work as a “file clerk”. There will be no paper chart to start or find, as all the patient information will be stored electronically. The file clerk staff person would likely have
other duties related to clinic operations, however, the role in facilitating a patient visit would no longer exist. With the option to schedule appointments online and eliminating the paper chart preparation from the workflow, the scheduling of appointments is simplified to just a few steps.

An advantage to having an EHR is that patient information, such as past visit vital signs, and other key metrics can be viewed all in one screen in order to see trends over time. The patient’s past medical history is stored so the patient does not need to be asked at every visit to document this information. The patient’s medications can be stored in the EHR. This creates less need to rely on paper records from previous visits to review medications. Validation of this information can be completed face to face with a nurse rather than the patient doing “paperwork” while in the waiting area. One of the complaints of patients in this clinic, is being asked to complete an encounter form while in the lobby with each visit including past medical history (PMH). It is a more personable experience for patients to have an interaction with the nurse to review this information, and it allows for immediate clarification of questions the patient or nurse may have regarding PMH. Documentation in the EHR is then completed in real-time.

Prior to seeing the patient, the provider can view the patient’s history and documentation of the nurse in the EHR in order to have a full picture of the patient’s concerns. The provider can enter the encounter with the patient and immediately engage the patient rather than looking at the paper records. She documents the examination and assessment as it is performed. Documentation at the point of service is preferred over documenting after the fact. It allows for support staff to view the provider’s notes if the patient were to call the clinic later with a question. With a paper record, the staff responding to the patient call would have to physically locate the paper chart and decipher the handwritten notes in order to obtain any information. Additionally, with an EHR, if the clinic is associated with a larger healthcare organization that
includes hospitals and urgent care or emergency departments, all providers may be able to access
the patient’s health record. This is extremely beneficial in the instance where someone is in need
of emergency care. The emergency department will have access to the patient’s allergies,
medications, chronic health conditions, and family history which could all affect the decision
making process in an emergent situation. Additionally, the primary care provider has immediate
access to the treatment that the patient receives while in the emergency department or while in-
patient.

EHR documentation in electronic form eliminates any potential errors from having notes
and orders hand written, (Seckman, 2014). This reduces the risk of misinterpreting orders. For
example, with a paper record, when processing a medication change, a clinic support staff may
misread some illegible handwriting and call in an erroneous medication or incorrect directions to
a patient’s pharmacy. In the event the support staff questions the order with the provider, it
would take time away from the support person addressing other issues in the clinic.

Regarding medications, most EHRs have the capacity to communicate directly with
pharmacies, forgoing the need for paper prescriptions or phone calls to pharmacies. This feature
will remove the risk of patient’s losing their paper prescriptions and reduce of incidents related
to transcription errors. Additionally, EHRs have built in features that monitor for risks
associated with documented allergies, medication interactions and prescribing information
related to medication dosages, (ONC, 2014). This promotes safety in prescribing medications.

Other ancillary systems that have the capacity to interface with a patient’s EHR include
laboratory and radiology. The benefit to this application is that results from testing can be
accessed from the EHR, again, keeping all patient records in one location, (Seckman, 2014). In
the paper health record environment, lab or radiology reports must be physically obtained from a
printer or fax machine, then manually filed into the patient chart. Managing test results automatically with an EHR is far less cumbersome and there is less risk of records getting misplaced or misfiled.

Another feature of an EHR is guidance embedded in the documentation that prompts the provider toward evidenced based practice including clinical decision support systems, (Meyer, 2014). This would enhance the provider’s ability to make clinic judgments by including information on the current treatment recommendation guidelines for various common acute or chronic conditions.

There are tremendous advantages to having an EHR in a primary care clinic. It allows for patients to actively engage in managing their health. It creates for a more streamlined visit for patients. It eliminates many areas of risk for patients. And EHRs improve the quality of information available to providers. All of these factors combine to create vast improvement in overall patient care and experience.
References

