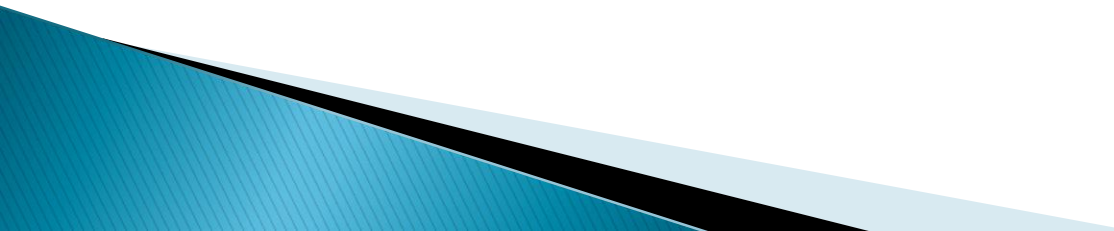


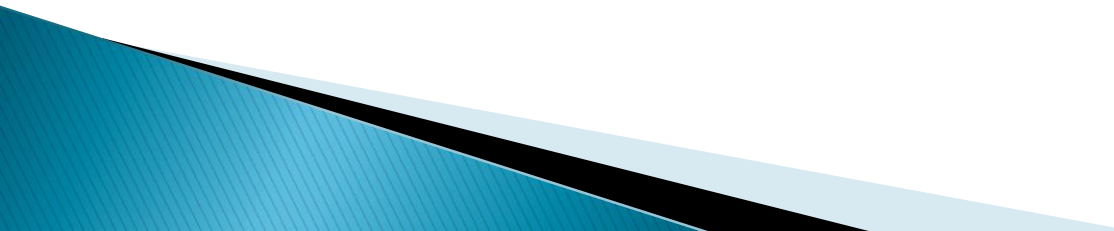
Improving Patient Care Through Meaningful Use of an Electronic Health Record

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Topics

- ▶ EHR and Clinical Documentation
 - ▶ EHR and VistA Imaging
 - ▶ EHR and Meaningful Use
 - ▶ EHR and Clinic Workflows
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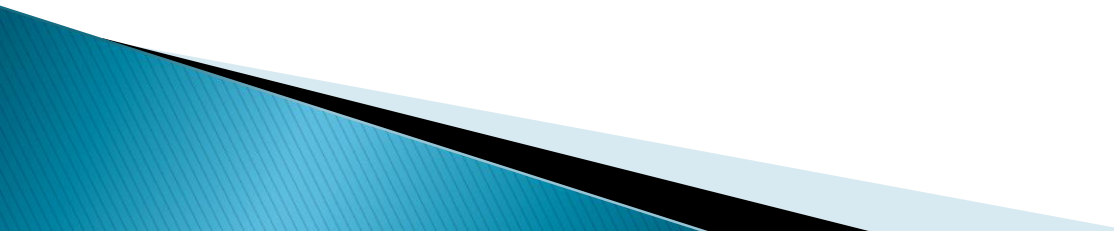
EHR and Clinical Documentation

- ▶ With advances in technology and various federal initiatives driving change, knowing how, where, and what to document is an unending challenge for organizations.
 - ▶ Remember...some aspects of our work with the paper health record are still relevant.
 - ▶ Both electronic and paper records require complete, accurate, and timely documentation for quality patient care.
 - ▶ The law defines timeliness as happening “at or near the time of the event”.
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AMA Principles of Documentation

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include: the date; the reason for the encounter; appropriate history and physical exam; review of lab, x-ray data and other ancillary services, where appropriate; assessment; and plan for care (including discharge plan, if appropriate).
3. Past and present diagnoses should be accessible to the treating and/or consulting physician.
4. The reasons for, and results of, x-rays, lab tests, and other ancillary services should be documented or included in the medical record.
5. Relevant health risk factors should be identified.
6. The patient's progress, including response to treatment, change in treatment, change in diagnosis, and patient non-compliance, should be documented.
7. The written plan for care should include, when appropriate: treatments and medications, specifying frequency and dosage; referrals and consultations; patient/family education; and specific instructions for follow-up.
8. The documentation should support the intensity of the patient evaluation and/or treatment, including thought processes and the complexity of medical decision-making.
9. All entries to the medical record should be dated and authenticated.
10. The CPT®/ICD-9 codes reported on the health insurance claim form or billing statement should reflect the documentation in the medical record.

EHR and VistA Imaging

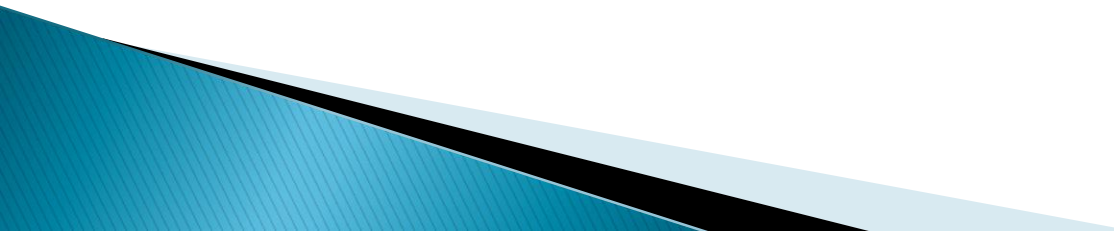
- ▶ VistA Imaging is a key component of moving to a fully electronic health record
 - ▶ It appears that VistA Imaging will be a significant part of the IHS plan for meeting Stage 2 meaningful use requirements.
 - ▶ Only a few remaining clinics that have not implemented VistA Imaging.
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EHR and Meaningful Use

- ▶ Participation in the CMS EHR Financial Incentive program requires meaningful use of a certified electronic health record.
- ▶ Workflow changes are frequently needed in order to meet the meaningful use requirements

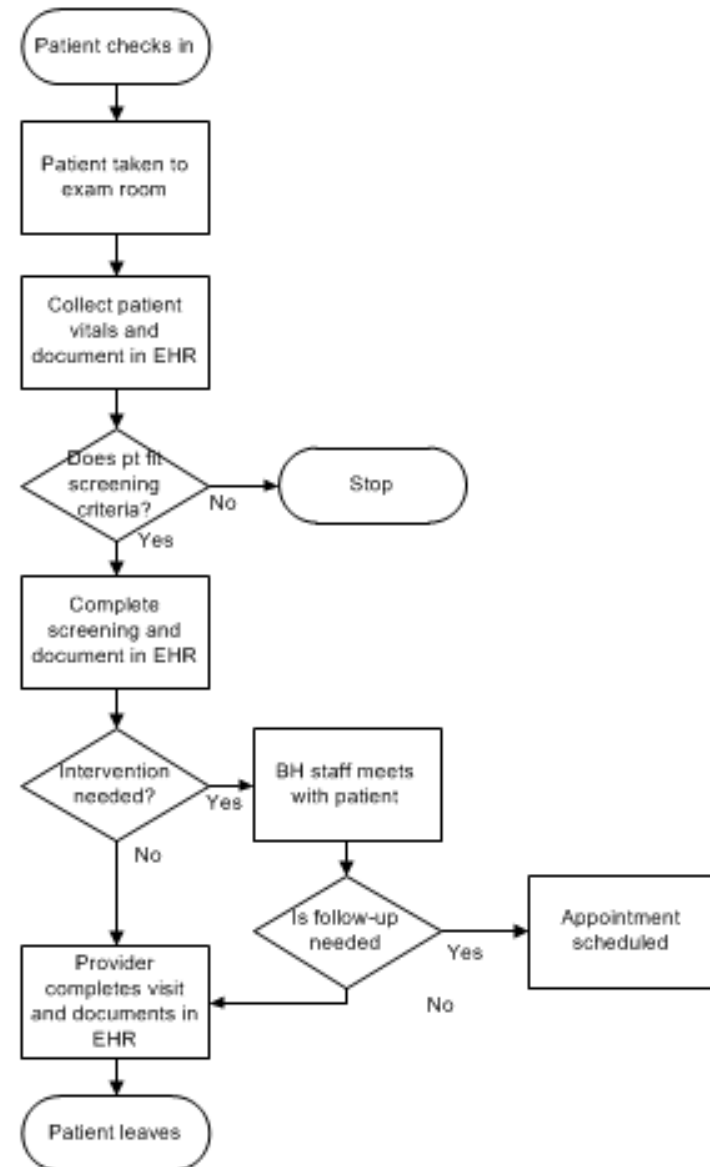
EHR and Clinic Workflows

Some clinic workflows impacted by the move to electronic health records are:

- ▶ Routine Screening
 - ▶ Immunizations
 - ▶ Colorectal Cancer Screening
 - ▶ Mammograms
 - ▶ Medication Management
 - ▶ Referrals
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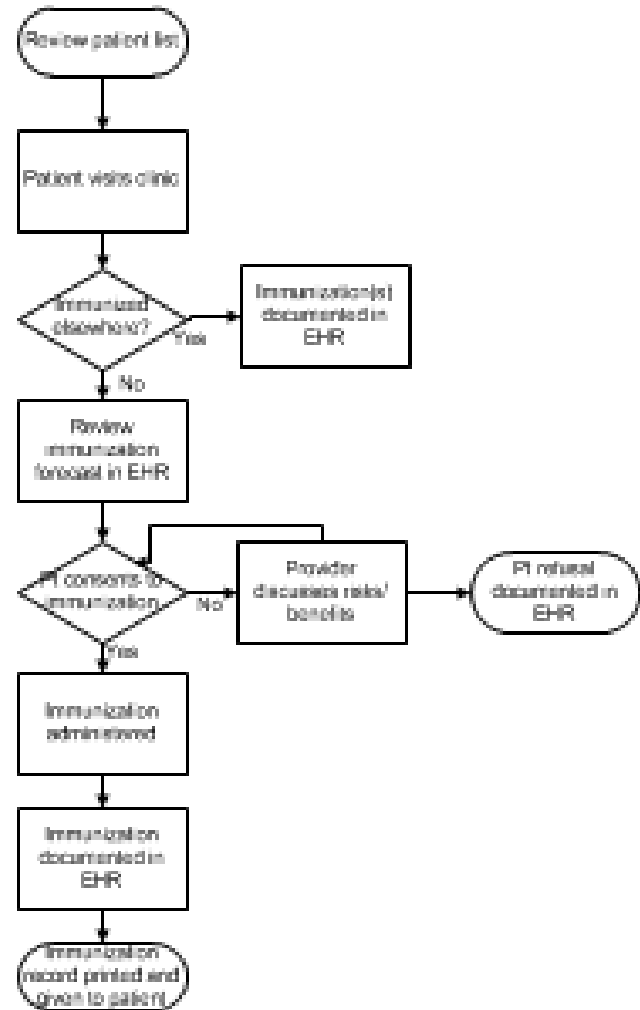
Routine Screening

Screening Workflow (Domestic Violence, Alcohol, Tobacco, and Depression)



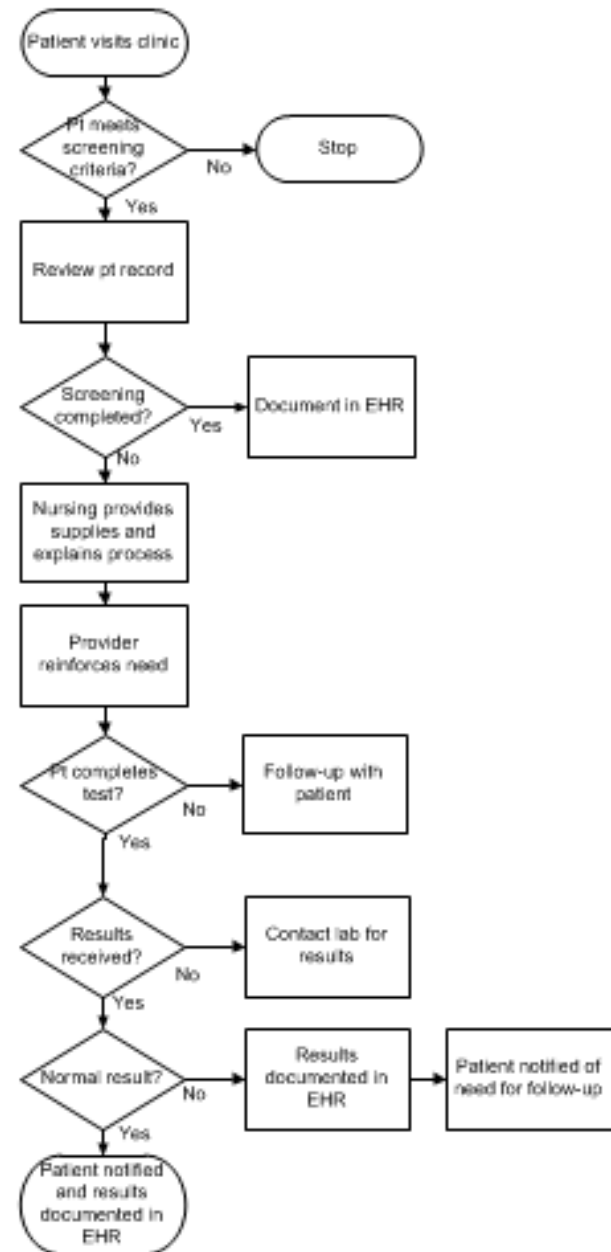
Immunizations

Adult Immunization Workflow

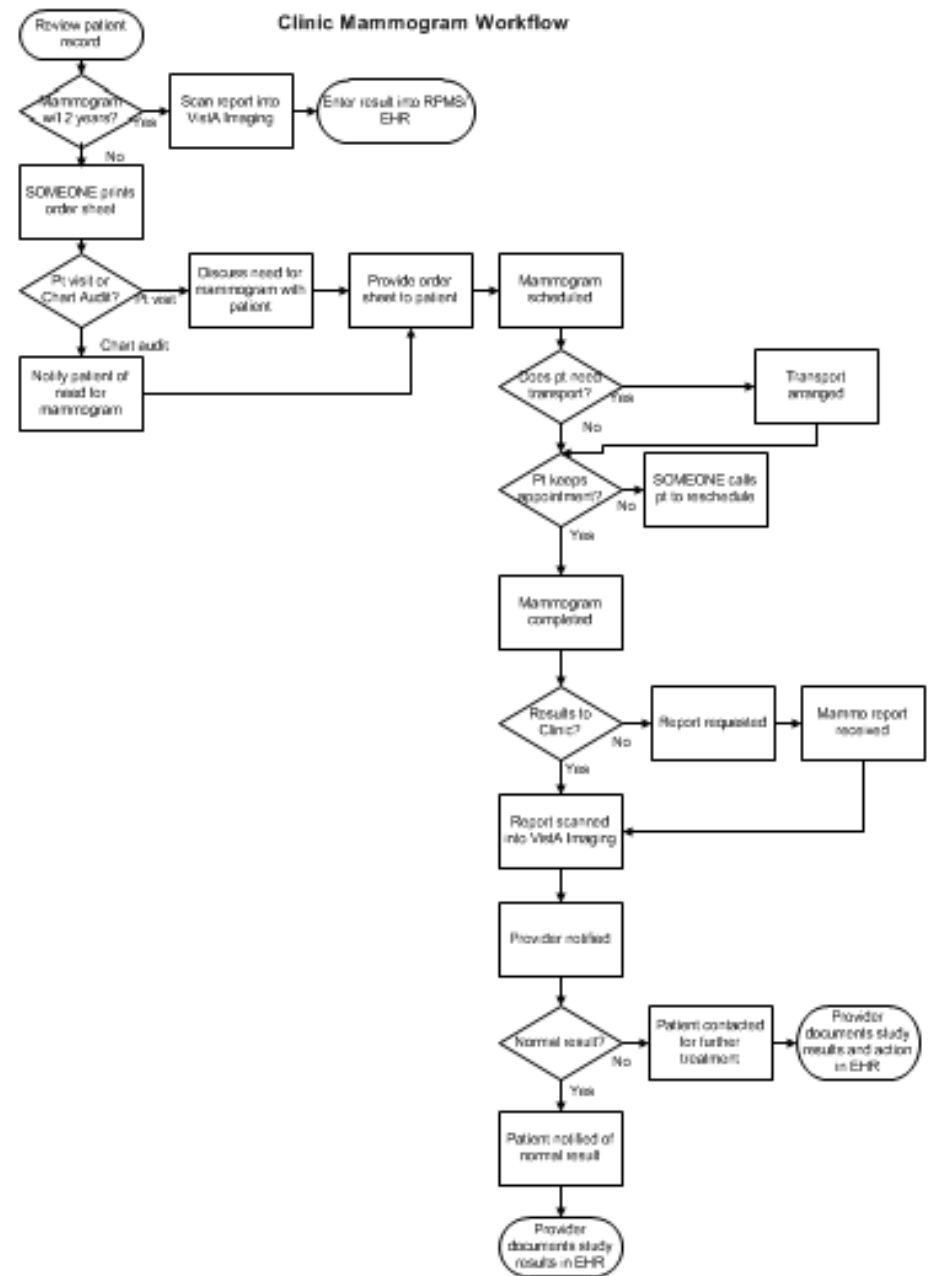


Colorectal Cancer

Colorectal Cancer Screening

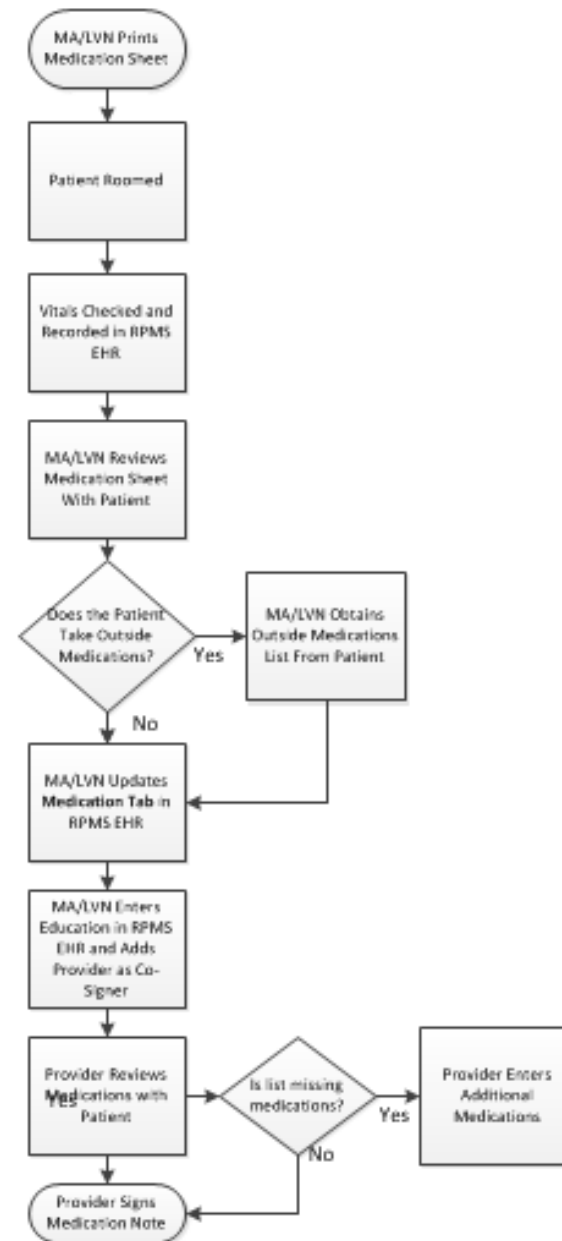


Mammograms



Medication Management

Medication Reconciliation Workflow



Referrals

Patient Referral Workflow





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EHR and VistA Imaging
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