

VistA Imaging



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IHS HIM Consultant
SSU HIM Director

Session Objectives

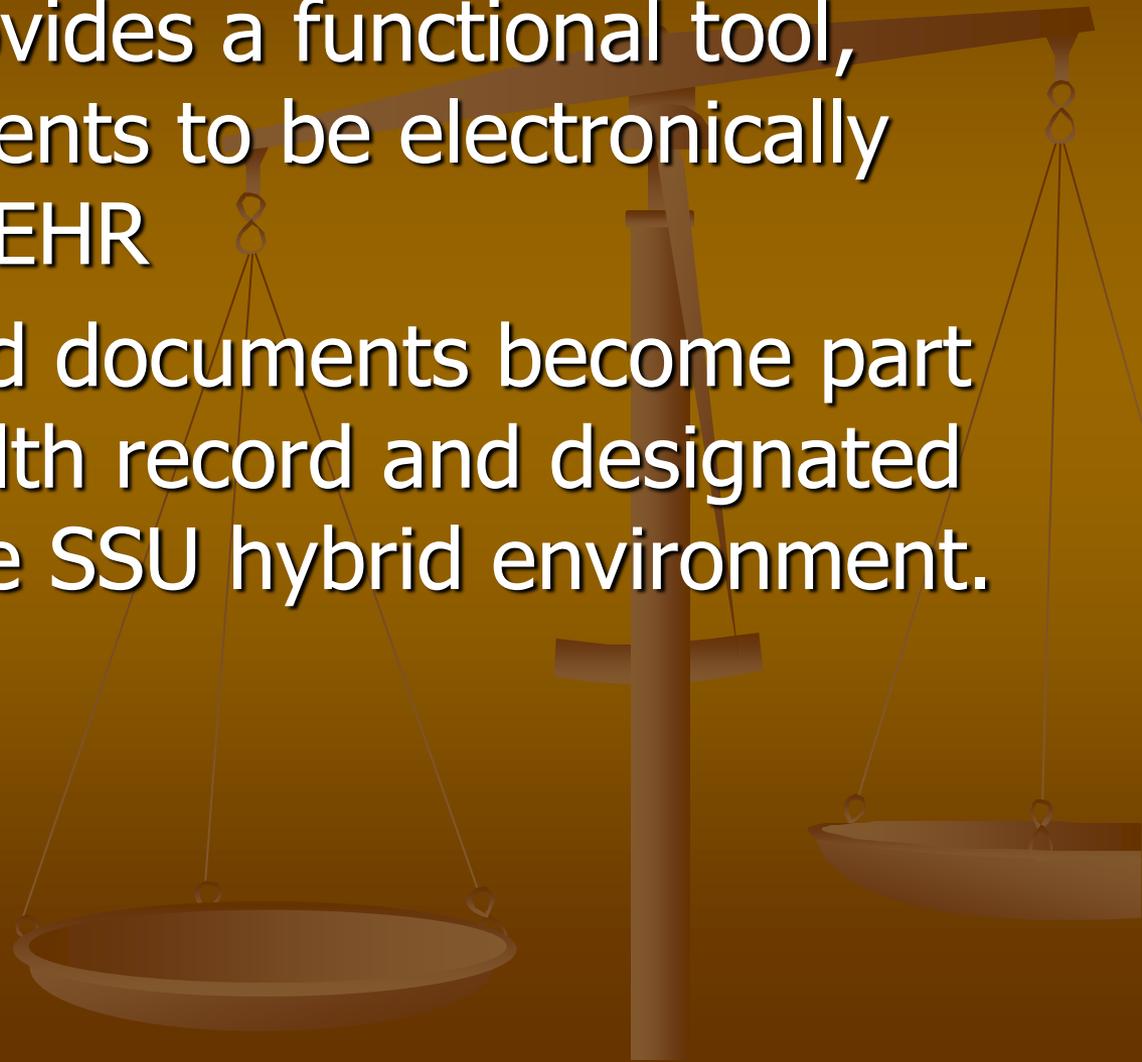
- Purpose
- Definitions
- Benefits
- Policies and Procedures
- Implementation and Preparation
- Approved documents
- 5 Steps to Quality
- Method and Notifications



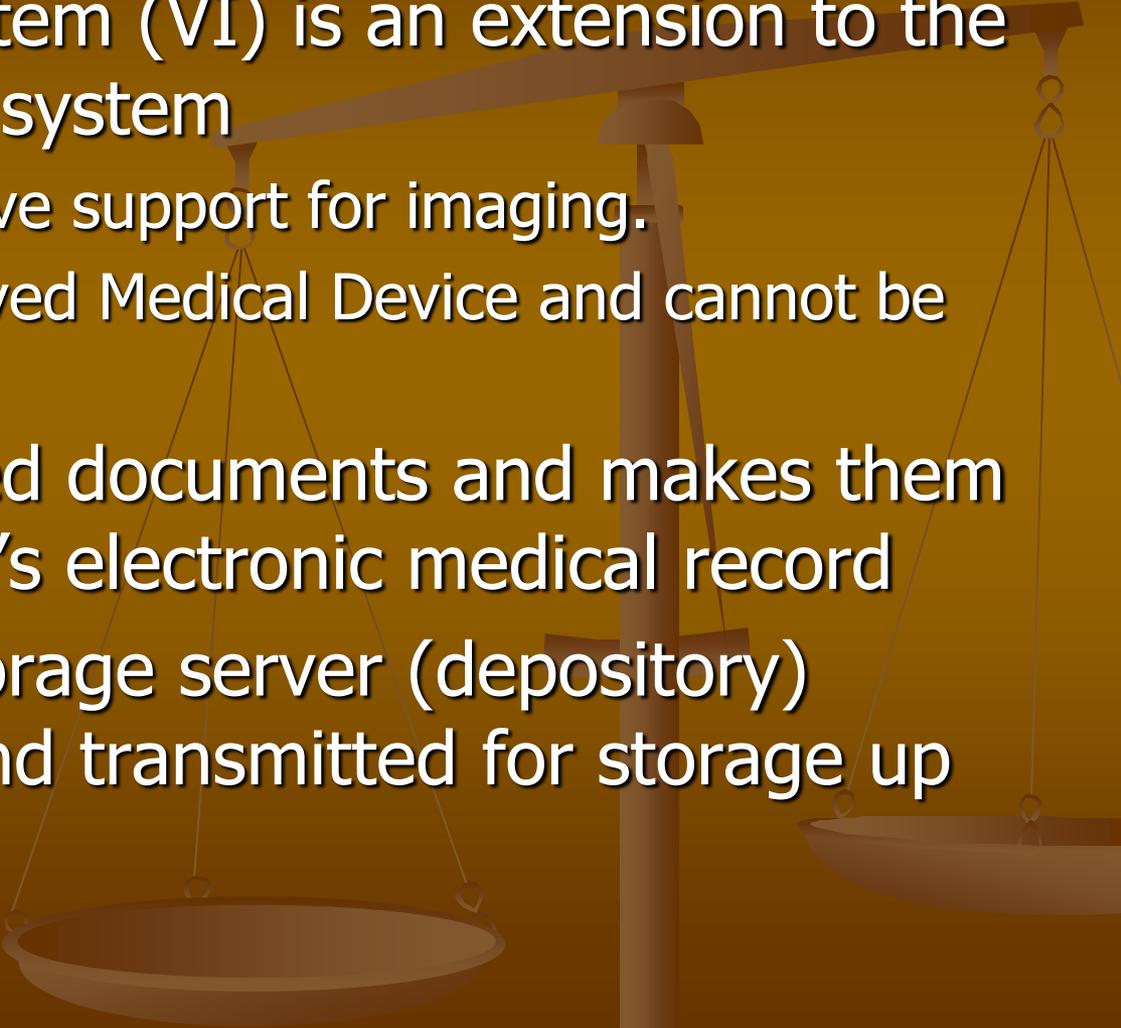
Purpose of VistA Imaging

Vista Imaging provides a functional tool, allowing documents to be electronically placed into the EHR

Scanned/uploaded documents become part of the legal health record and designated record set in the SSU hybrid environment.

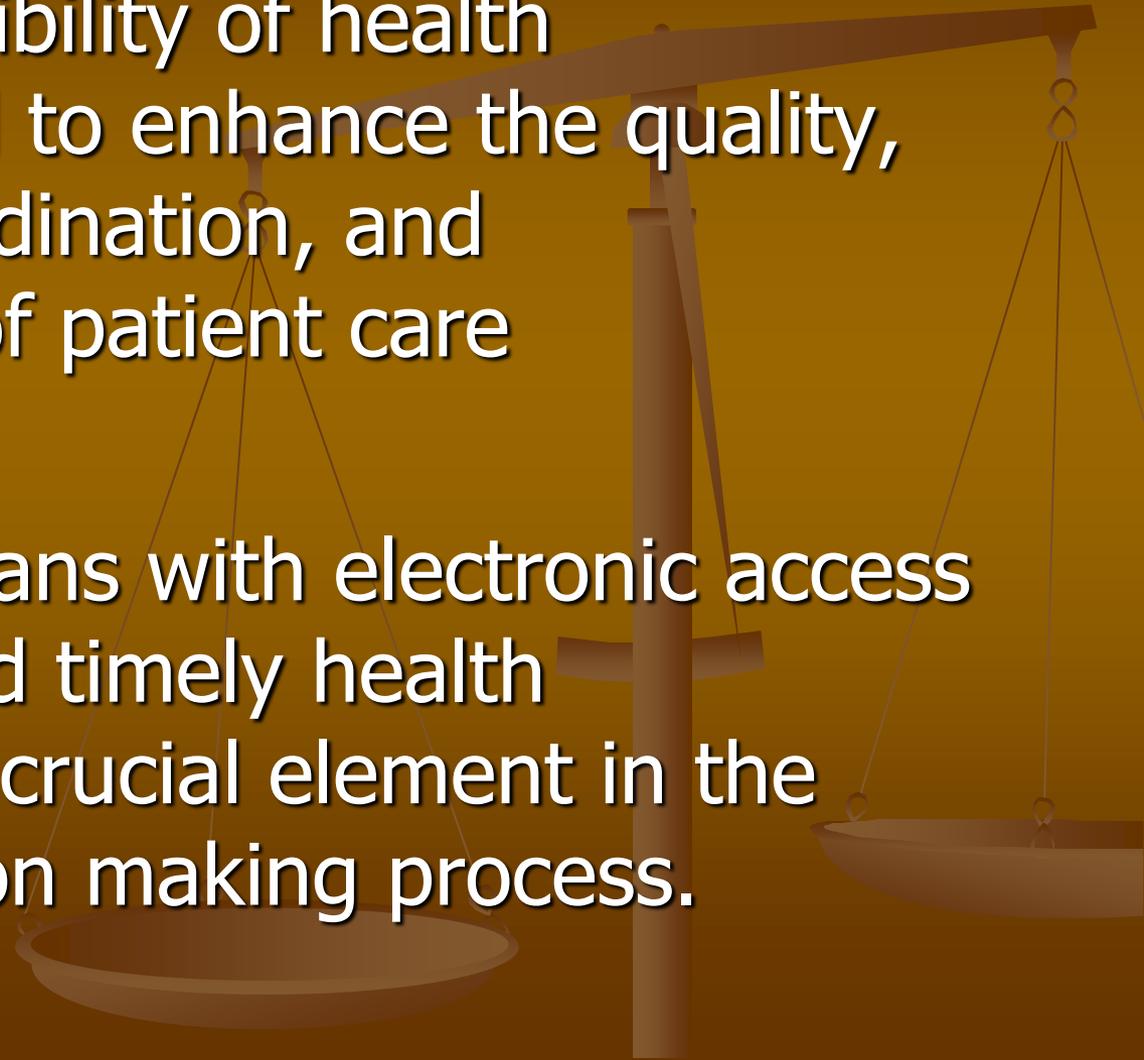


Definition

- VistA Imaging System (VI) is an extension to the RPMS information system
 - VI provide extensive support for imaging.
 - VI is a FDA Approved Medical Device and cannot be modified
 - It captures scanned documents and makes them part of the patient's electronic medical record
 - Areas have the storage server (depository) which is purged and transmitted for storage up to 75 plus years.
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Benefits:

- Improve accessibility of health information and to enhance the quality, continuity, coordination, and longitudinality of patient care
- Provides clinicians with electronic access to accurate and timely health information; a crucial element in the medical decision making process.



Policy

- Approved document list
- Training
- Equipment
- Management
- QA

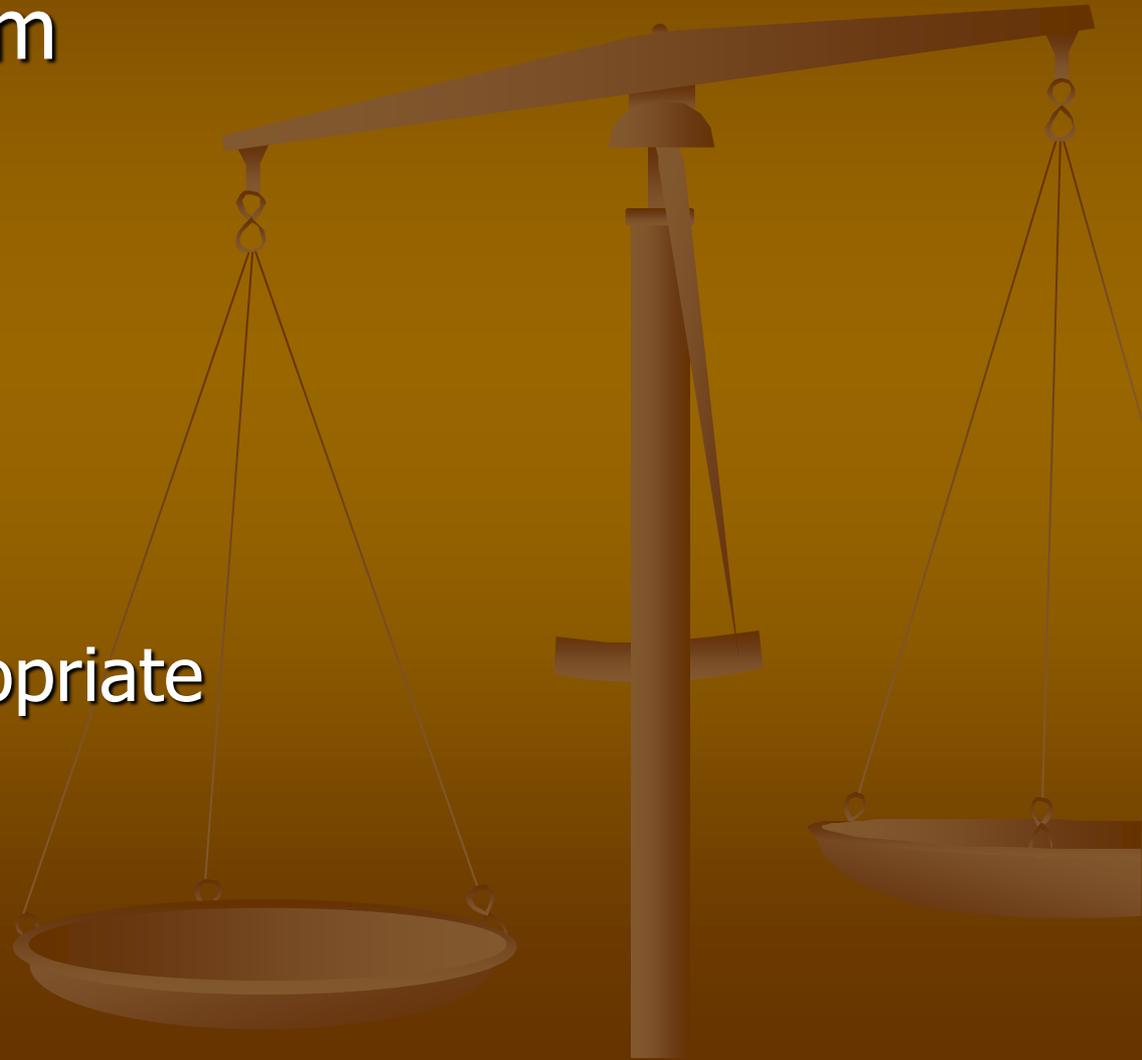
Sample policy available on ihs.gov

Go to "V" for VistA Imaging on FTP site



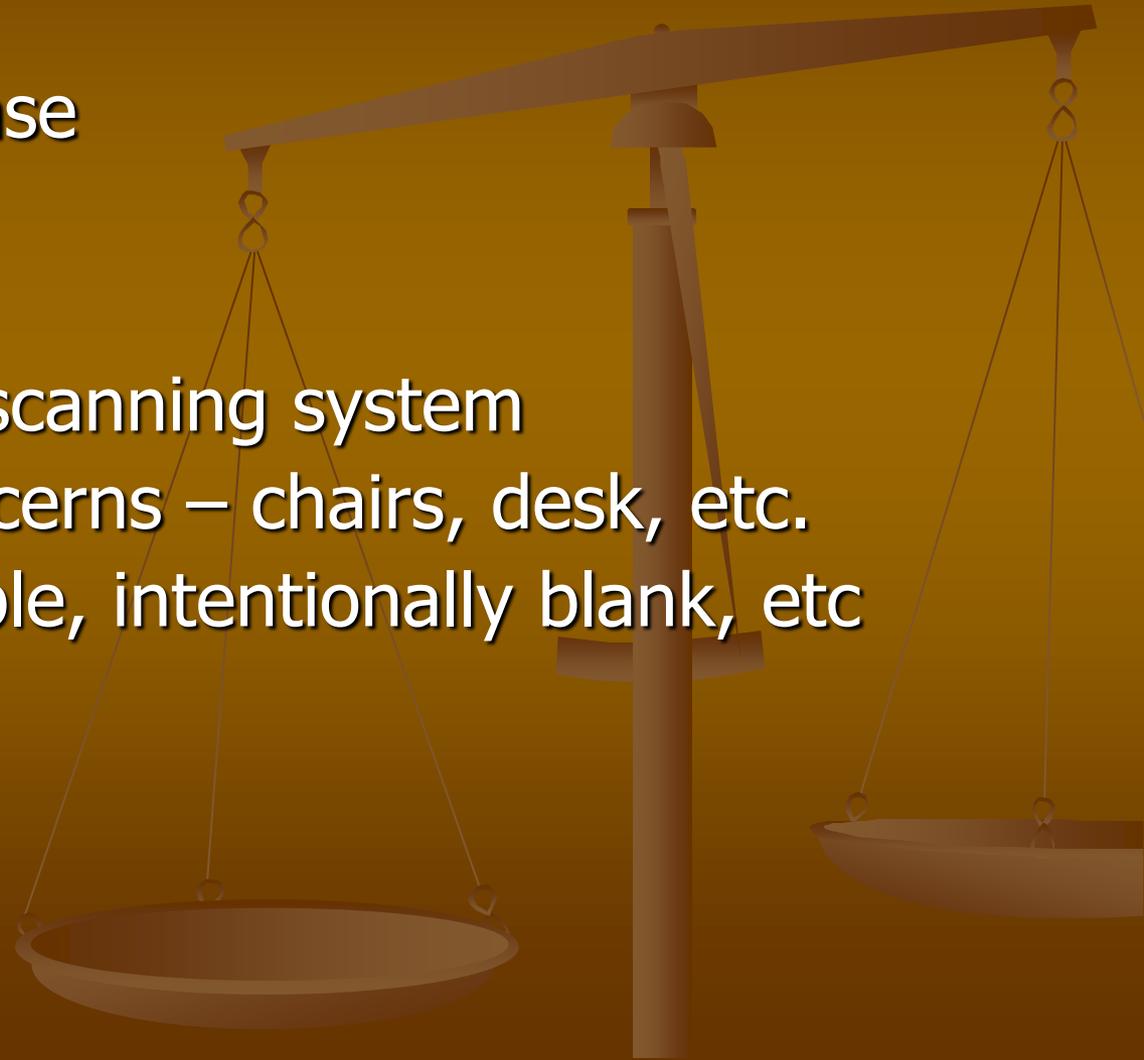
Vista Imaging Implementation

- Identify the team
 - HIM Director
 - Providers
 - CAC
 - Radiology
 - IT
 - Others as appropriate



PREPARATION

- Site Visit
- Equipment Purchase
 - Server
 - Scanners
 - FDA approved scanning system
 - Ergonomic Concerns – chairs, desk, etc.
 - Stamps – illegible, intentionally blank, etc
- Scanner locations
- Training



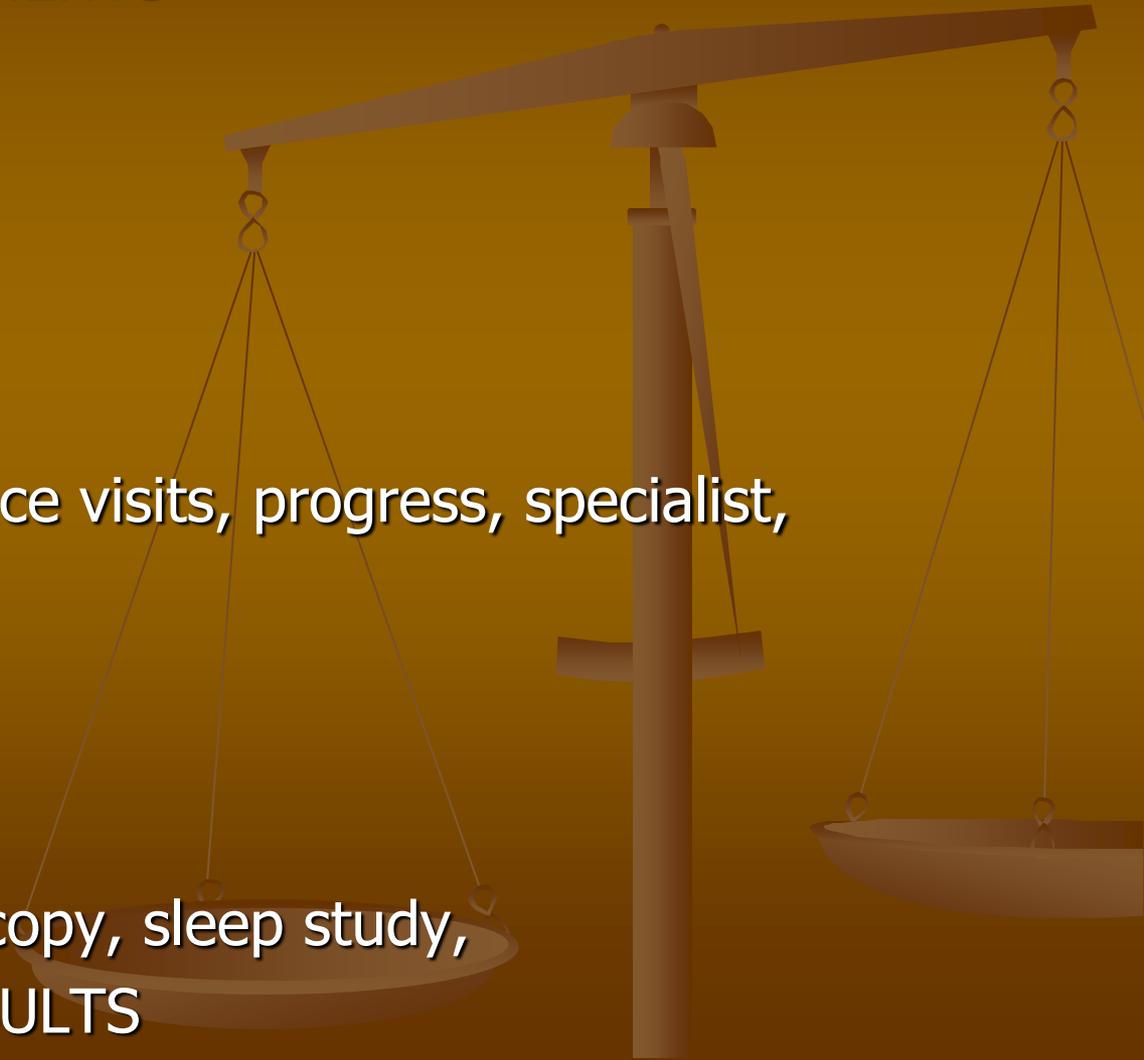
Approved Clinical Documents

CONTRACT HEALTH DOCUMENTS

- ALL CLINICAL DOCUMENTS

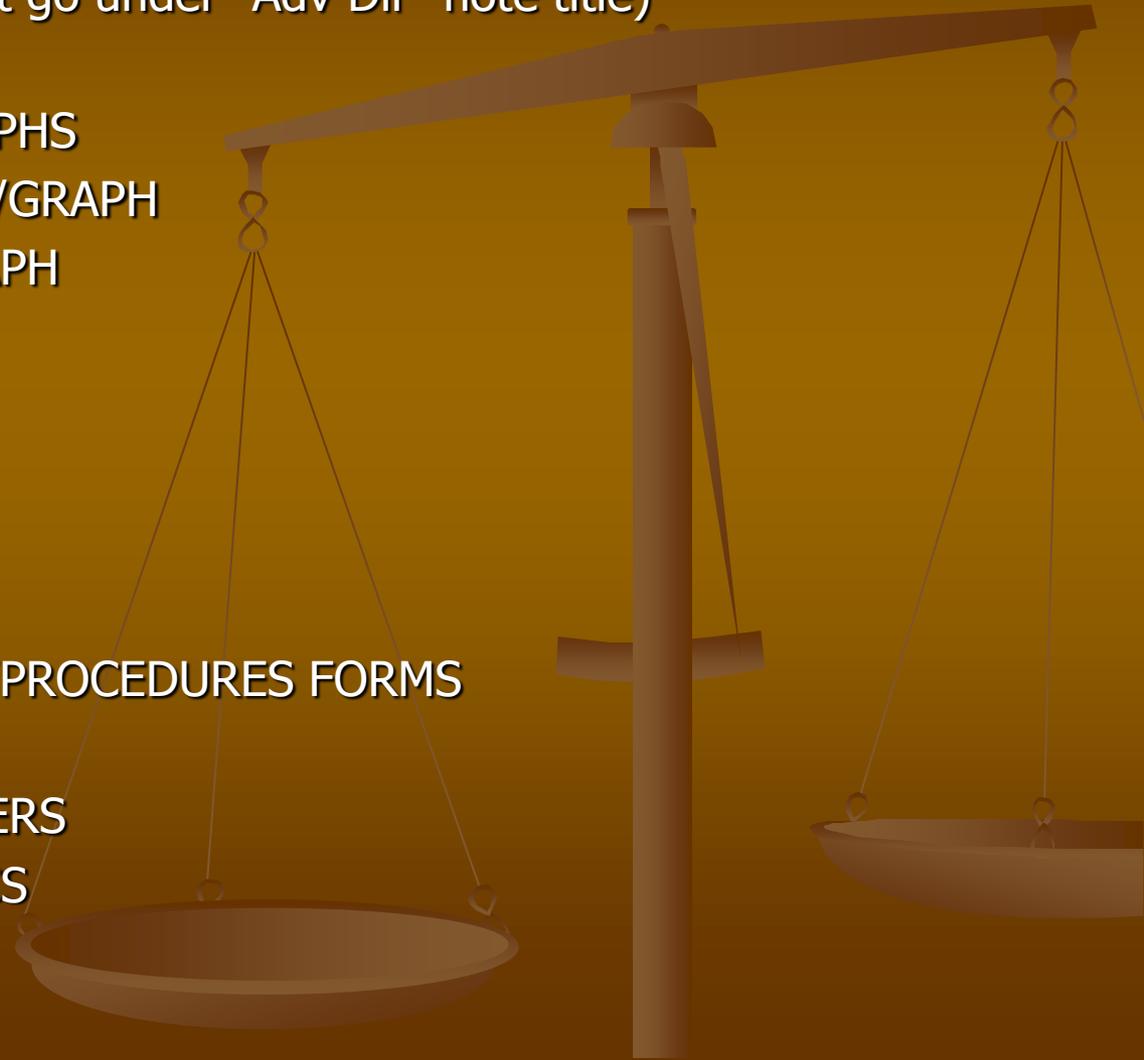
OUTSIDE DOCUMENTS

- DISCHARGE SUMMARY
- H&P
- CONSULTS
- OP REPORTS
- CLINIC NOTES (ED, office visits, progress, specialist, consultation)
- MEDICATION SCRIPTS
- MED LIST
- PROBLEM LIST
- PROCEDURES (colonoscopy, sleep study,)
- DIAGNOSTIC TEST RESULTS



■ **SSU INTERNAL DOCUMENTS**

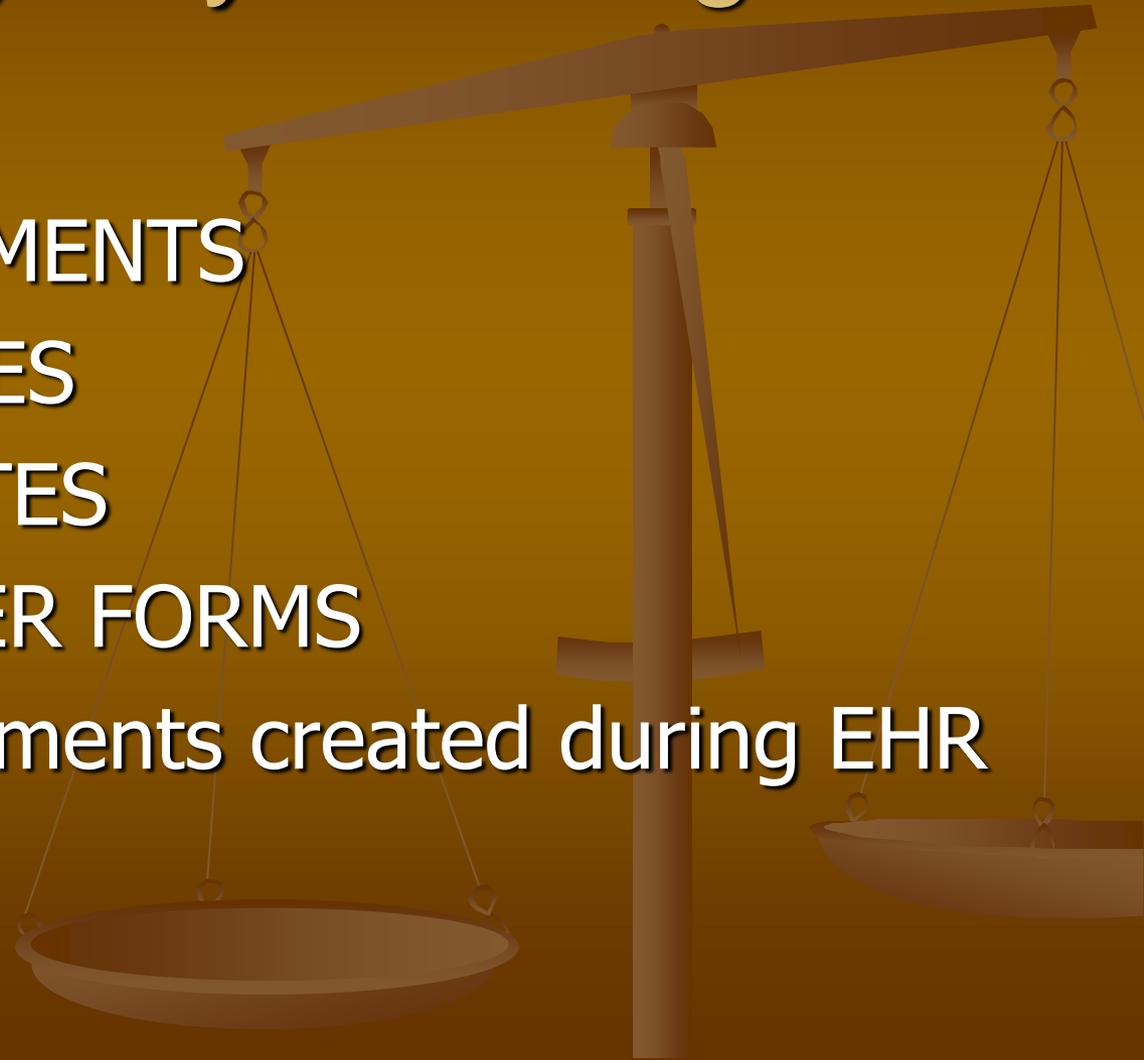
- PCC - Mobile Clinic, PHN, Jail, contract Consultants/Specialists visits
- PCC - ER/ED
- EKG/ECHOCARDIOGRAM/HOLTER
- ADVANCE DIRECTIVES (must go under "Adv Dir" note title)
- VISUAL FIELD FORMS
- AUDIOLOGY DRAWING/GRAPHS
- OPHTHAMOLOGY DRAWING/GRAPH
- OPTOMETRY DRAWING/GRAPH
- ENT DRAWING/GRAPH
- ULTRA SOUNDS
- AUDIOLOGY EAR CHARTS
- MAMMOGRAMS
- URODYNAMIC REPORTS
- CONSENT FOR TREATMENT/PROCEDURES FORMS
- ADVANCE DIRECTIVES
- PATERNITY/ADOPTION PAPERS
- COURT-APPT CUSTODY DOCS
- GUARDIANSHIP



Approved Clinical Documents Contingency Planning

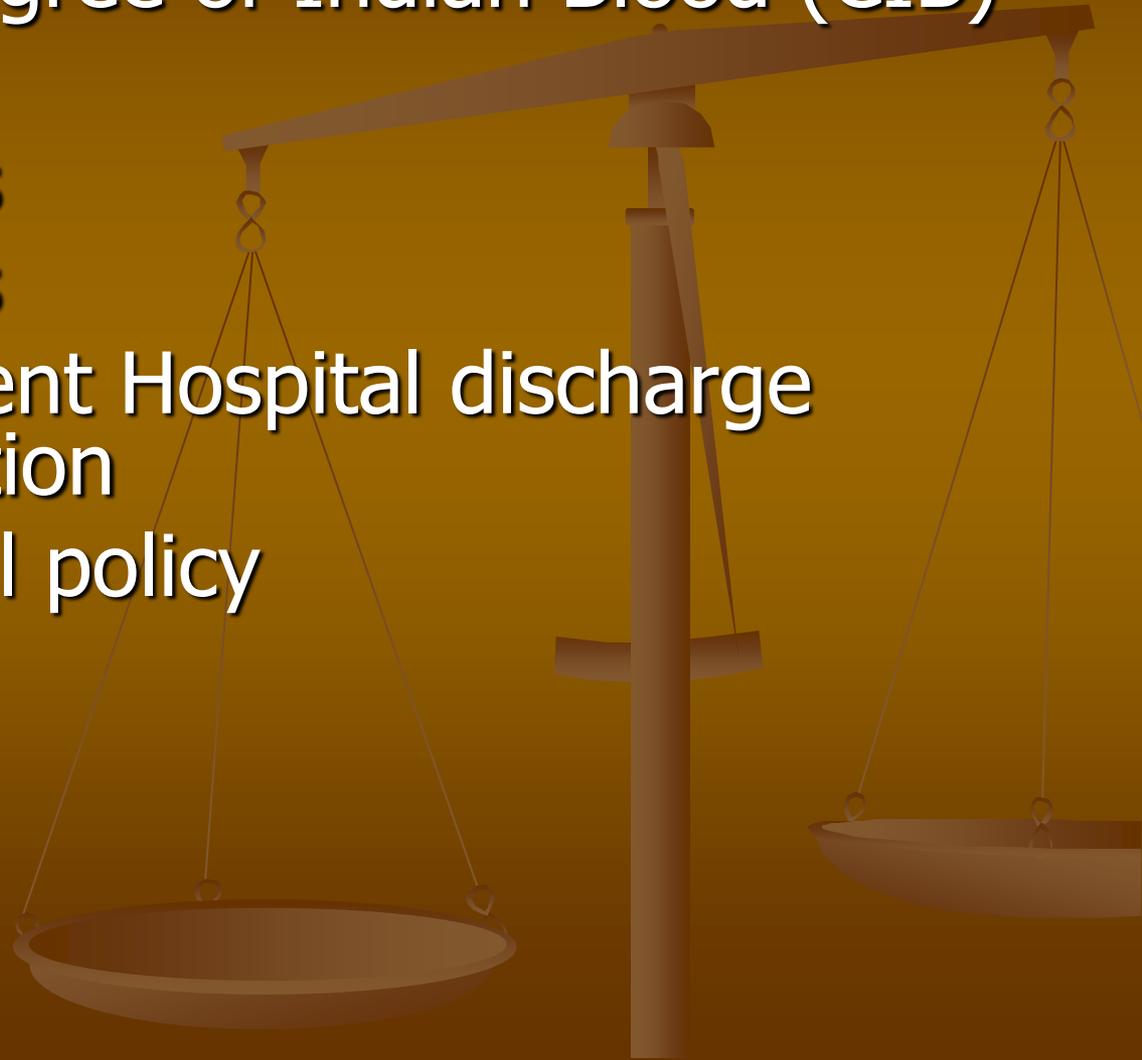
INTERNAL DOCUMENTS

- DOCTORS NOTES
- PROGRESS NOTES
- PCC ENCOUNTER FORMS
- All Clinical documents created during EHR outage



Approved Admin Documents

- Certificate of Degree of Indian Blood (CIB)
- Insurance Card
- Paternity Papers
- Adoption Papers
- Medicare Inpatient Hospital discharge appeals notification
- Other – per local policy



The 5 steps to Quality!

1. Sort and Prepare
2. Prescreen
3. Scan
4. Quality Assessment
5. Reports



Sort and Prepare

Scan Technicians receive stacks of documents daily

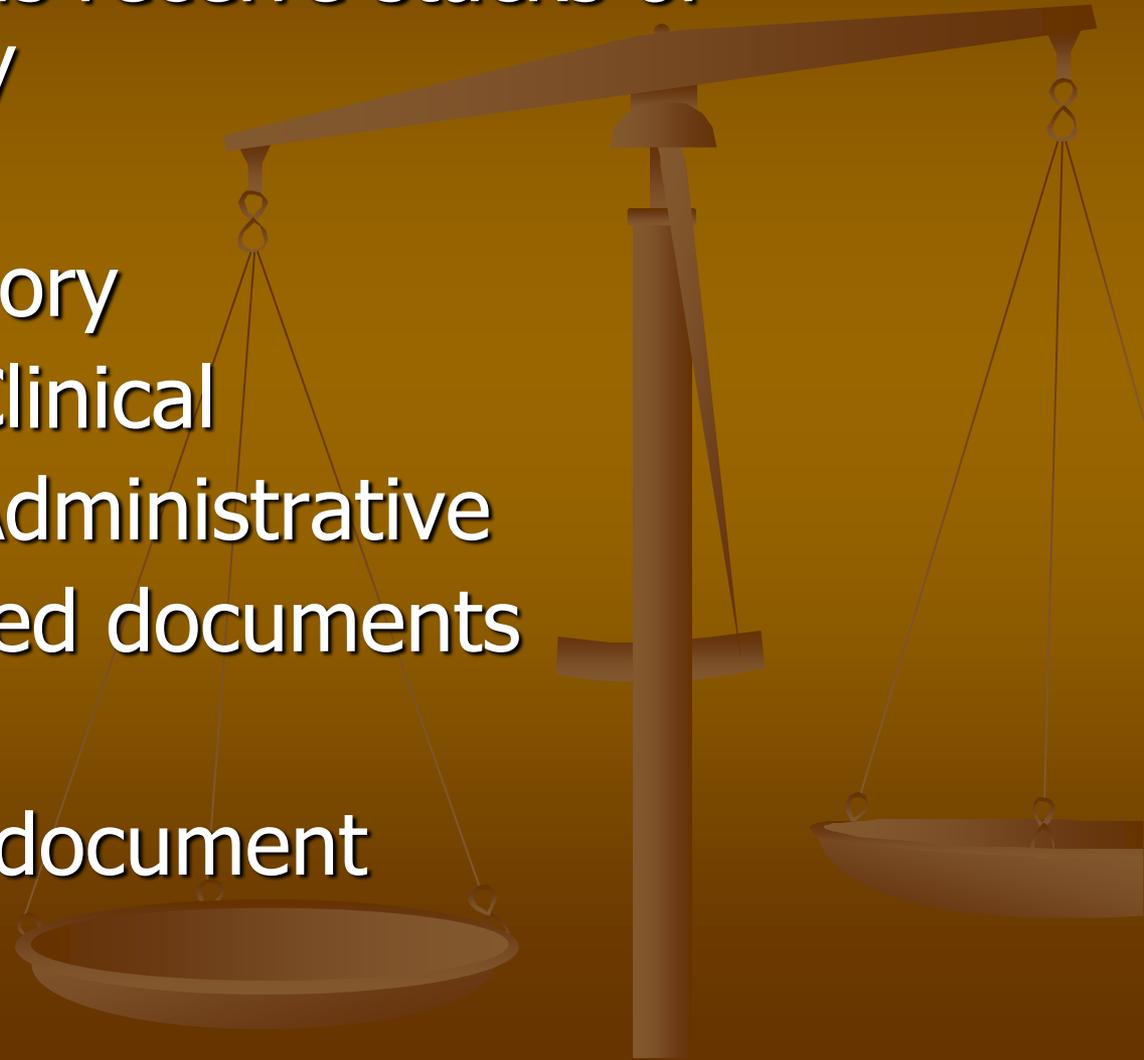
Sorted by category

Authorized Clinical

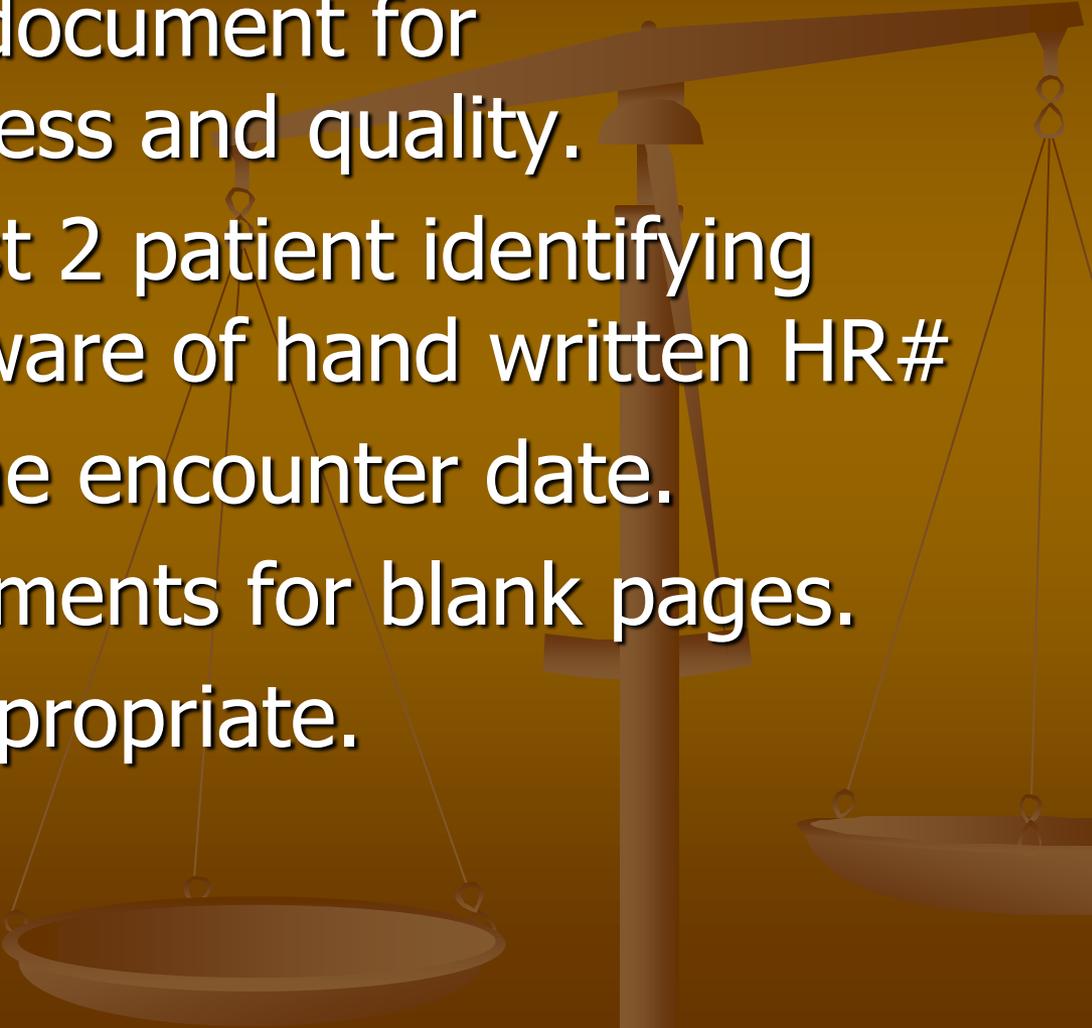
Authorized Administrative

Not authorized documents

Sort by type of document



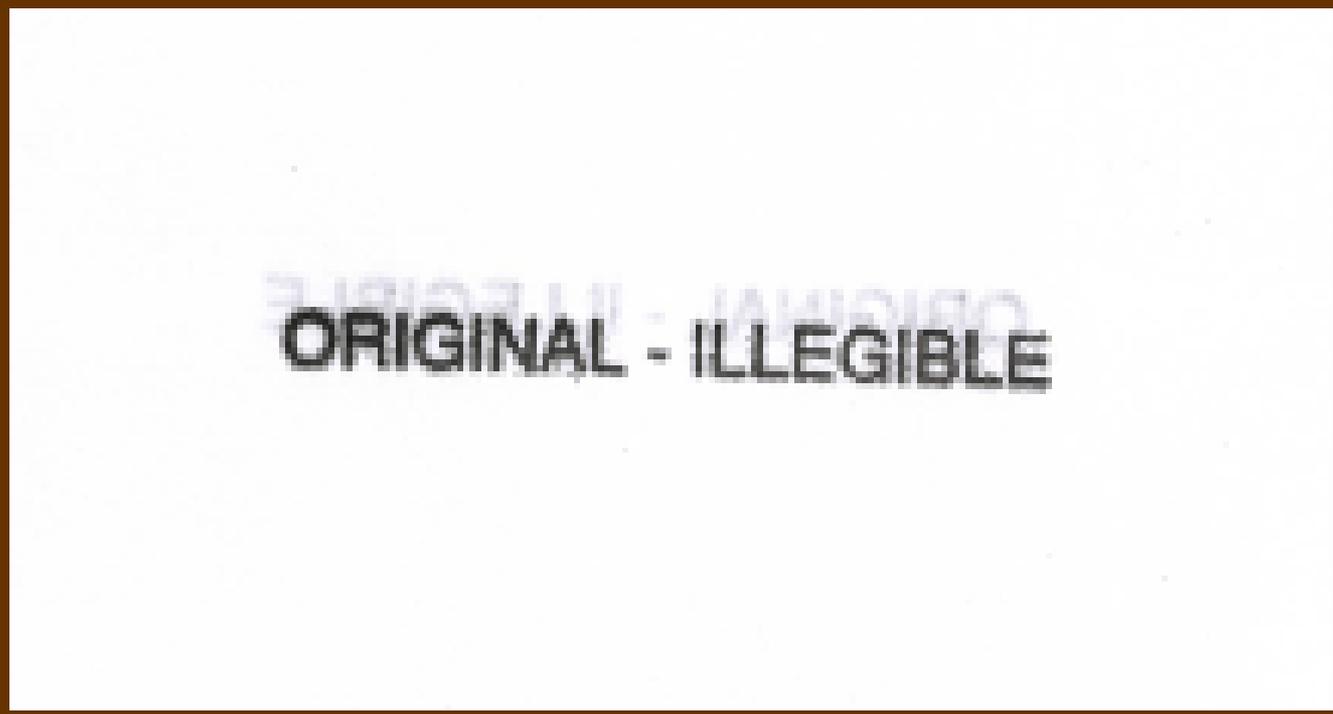
Prescreening



1. Review the document for appropriateness and quality.
2. Verify at least 2 patient identifying items. Be aware of hand written HR#
3. Determine the encounter date.
4. Review documents for blank pages.
5. Stamp as appropriate.

STAMPS

- ILLEGIBLE
- INTENTIONALLY LEFT BLANK
- SCANNED DATE-INITIALS
- RECEIVED BY HIM



ORIGINAL - ILLEGIBLE

Note date versus document image date....

For every item scanned, the day the patient was actually physically seen is entered as the Vista note date. This will help scanned documents match up with the encounter dates in the E.H.R.

Document image date is the day it was scanned.

Vista Imaging Capture : []

File Options Tools Configurations System Manager Image Help

Source: TWAIN Format: True Color JPG (24 bit) Association: TIU Saying: Single Mode: OnLine Other:

- Blood transfusion
- Consent FD IHS 515
- Prenatal visit
- Referral to Fort Defiance
- Outside Lab other
- ROI
- Referral Out
- Culposcopy
- Consent Transfer HRSA-351
- outside lab pap smear
- Outside Lab Path
- P.H.N. Visit
- EKG
- C.T.
- Ultrasound
- X-ray (CR)
- Mammography
- Ref Lab Other
- Ref Lab Pap Smear

Select Patient

*Patient

Select Progress Note

*Note Title

Note-Status-Loc

*Note Date

*Doc/Image Date

*Origin

VA

*Doc/Image Type

Specialty

Proc/Event

*Image Desc

Capture...

MultiPg Doc.

Image OK

Cancel

Bri 100 Con 100 Zoom 100 pg 0 of 0



viewing image :

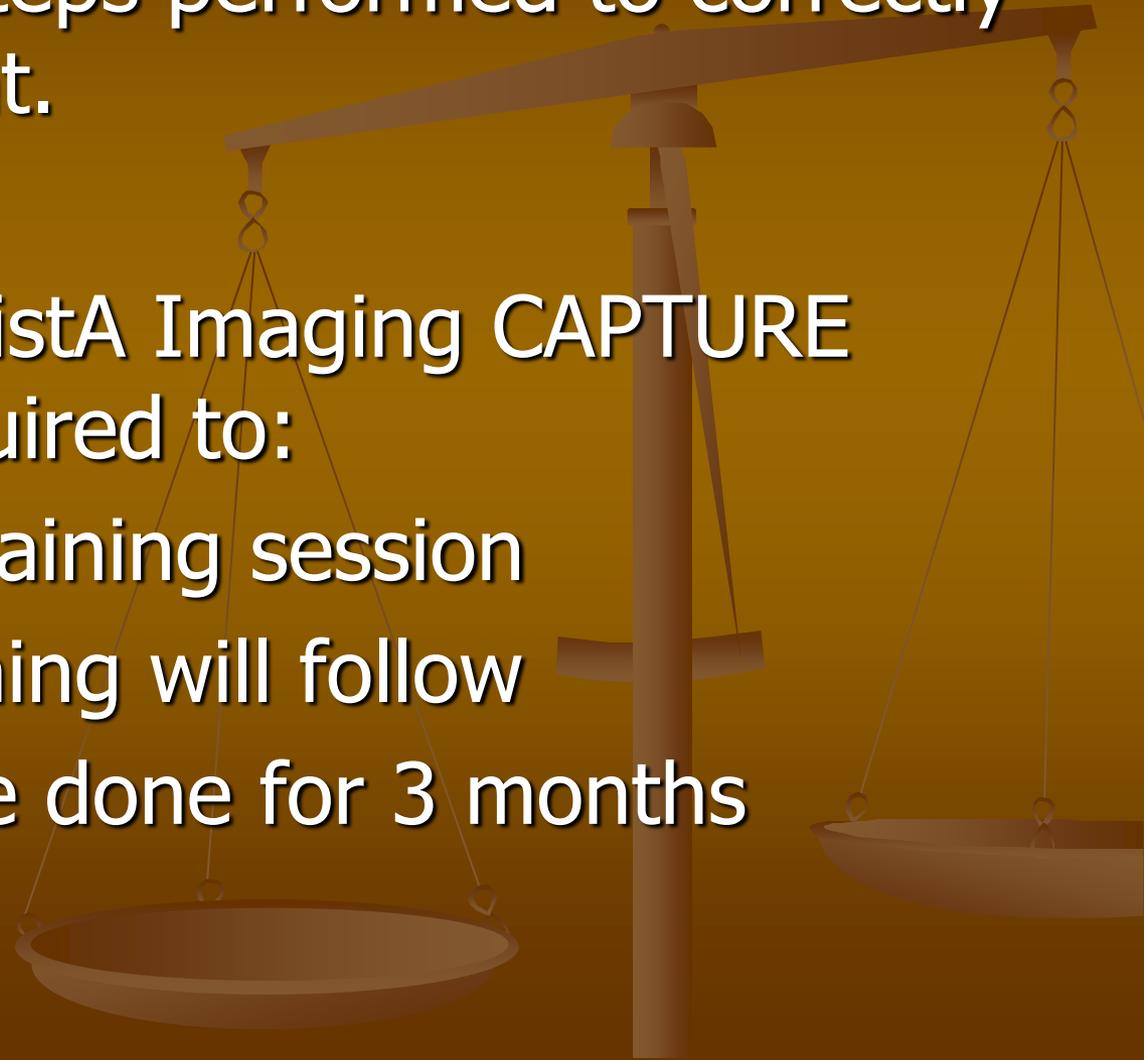
*Document Image dates
enter here*

Scan

There are many steps performed to correctly scan a document.

Anyone allowed VistA Imaging CAPTURE keys will be required to:

- Attend 4 hour training session
- On-the-Job training will follow
- 100% QA will be done for 3 months



Vista Imaging Capture Software

The screenshot displays the Vista Imaging Capture software interface. At the top, the title bar reads "Vista Imaging Capture : () in use by: ..". Below the title bar is a menu bar with "File", "Options", "Tools", "Configurations", "System Manager", "Image", and "Help".

The main interface features a grid of configuration buttons. A black oval highlights a row of buttons: "Blood transfusion", "Consent FD IHS 515", "Prenatal visit", "Referral to Fort Defiance", "Outside Lab other", and "ROI". Below this, another row of buttons includes "Referral Out", "Culposcopy", "Consent Transfer HRSA-351", "E.D. Visit", "outside lab pap smear", "Outside Lab Path", "P.H.N. Vis", and "EKG". A third row contains "C.T.", "Ultrasound", "X-ray (CR)", "Mammography", "Ref Lab Other", "Ref Lab Pap Smear", and "Ref Lab Path".

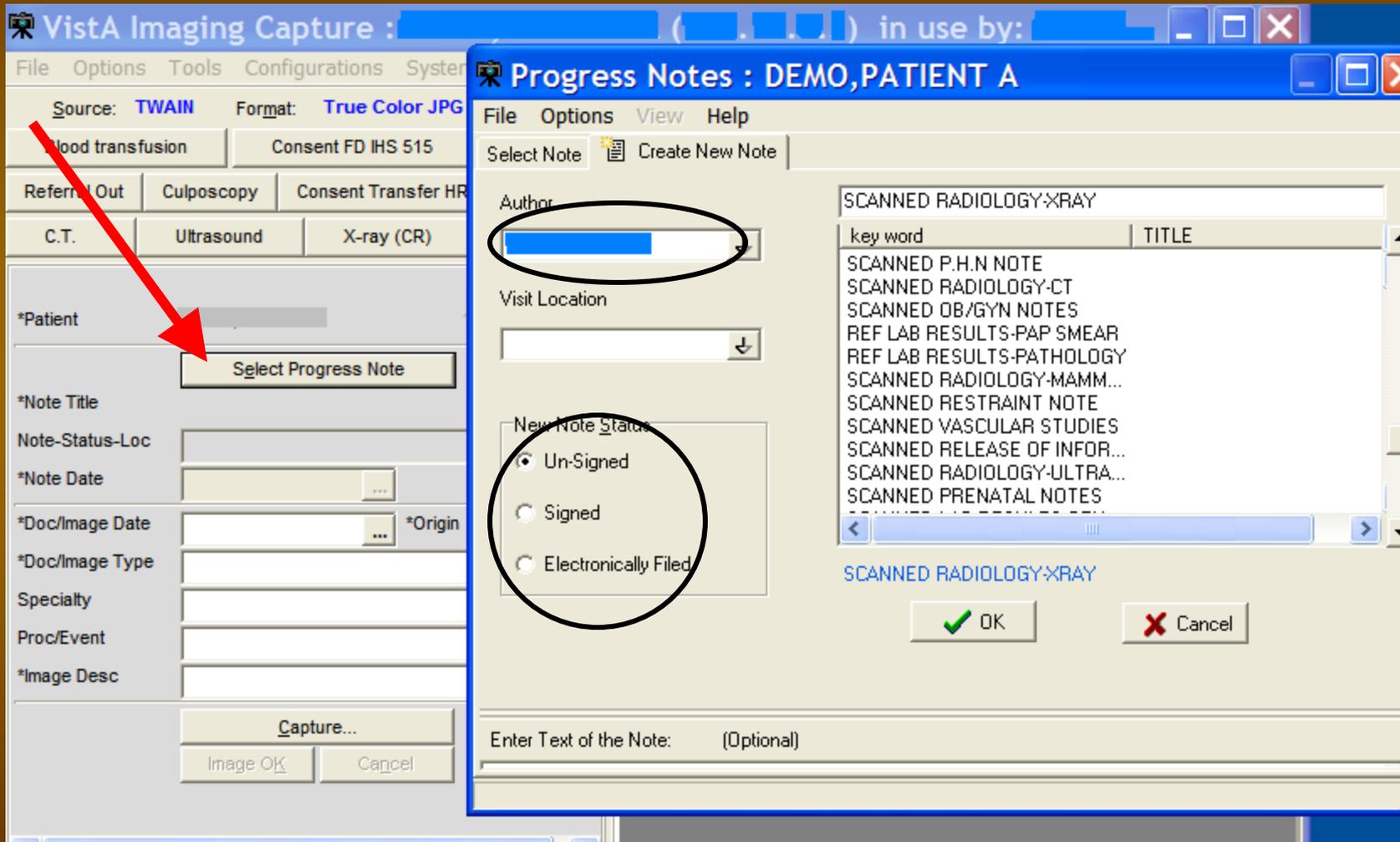
Below the grid is a form for patient and note information. Fields include: "*Patient", "*Note Title" (with a "Select Progress Note" button), "Note-Status-Loc", "*Note Date", "*Doc/Image Date", "*Doc/Image Type", "Specialty", "Proc/Event", and "*Image Desc". There are also "Capture...", "Image OK", and "Cancel" buttons. A "MultiPg Doc." checkbox is present.

On the right side, there are controls for "Bri 100", "Con 100", and "Zoom 100". Below these are navigation buttons and a "pg 0 of 0" indicator. A toolbar with various icons is visible, and the text "viewing image : #bits" is shown.

At the bottom, the status bar shows "FDH" and "Patient :".

Your IRM staff will be able to change the configuration buttons to match your document's needs. Carefully choose the corresponding tab.

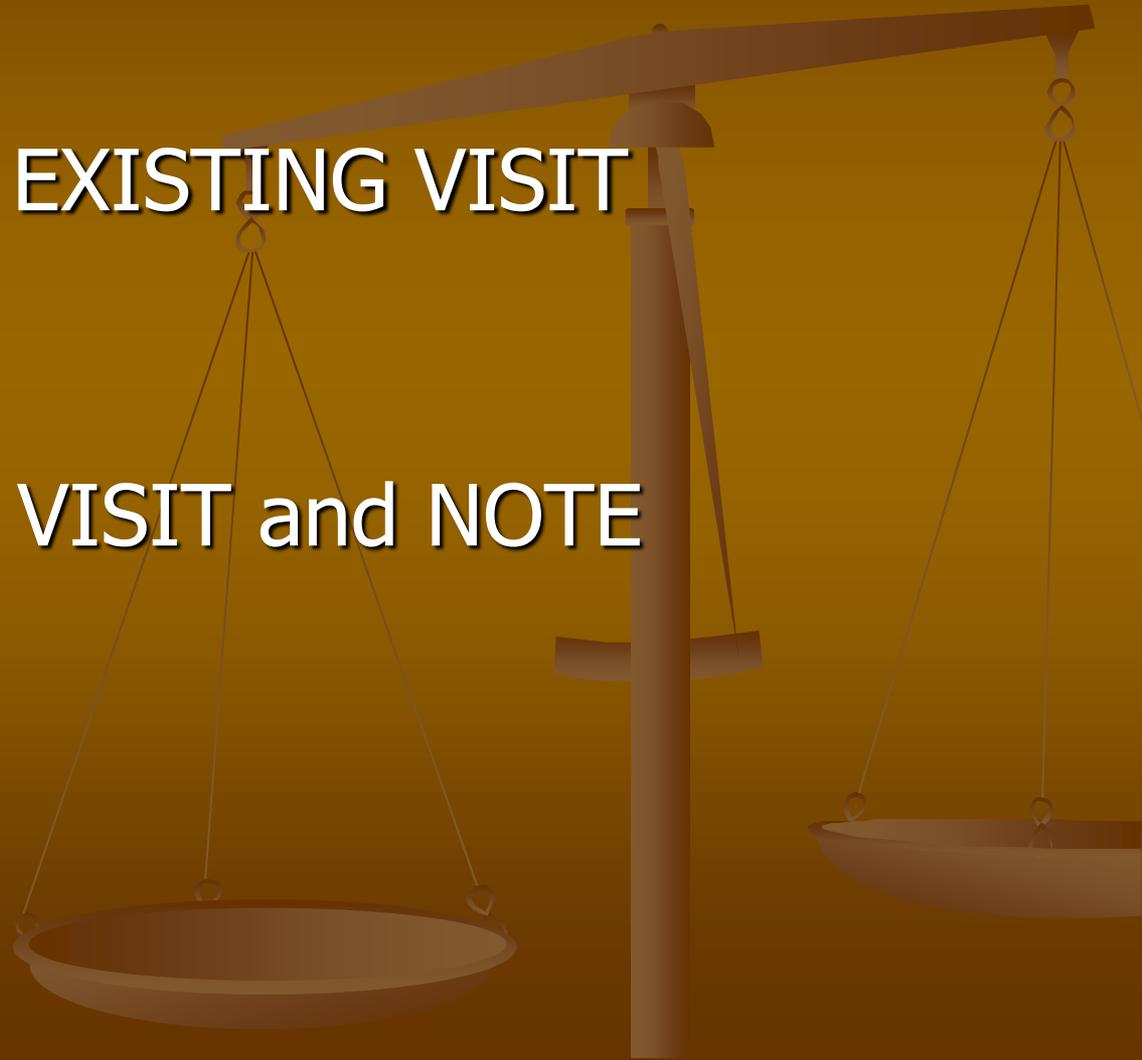
Progress Note window



Scan Methods

Clinical Documents

- ATTACH TO AN EXISTING VISIT
 - ADDENDUM
 - Note Title
- CREATE A NEW VISIT and NOTE
 - Clinic Code
 - Note Title



Filing

- Unsigned
- Signed
- E file



Notifications

- E signature
- Identify additional signer
- Manual notification

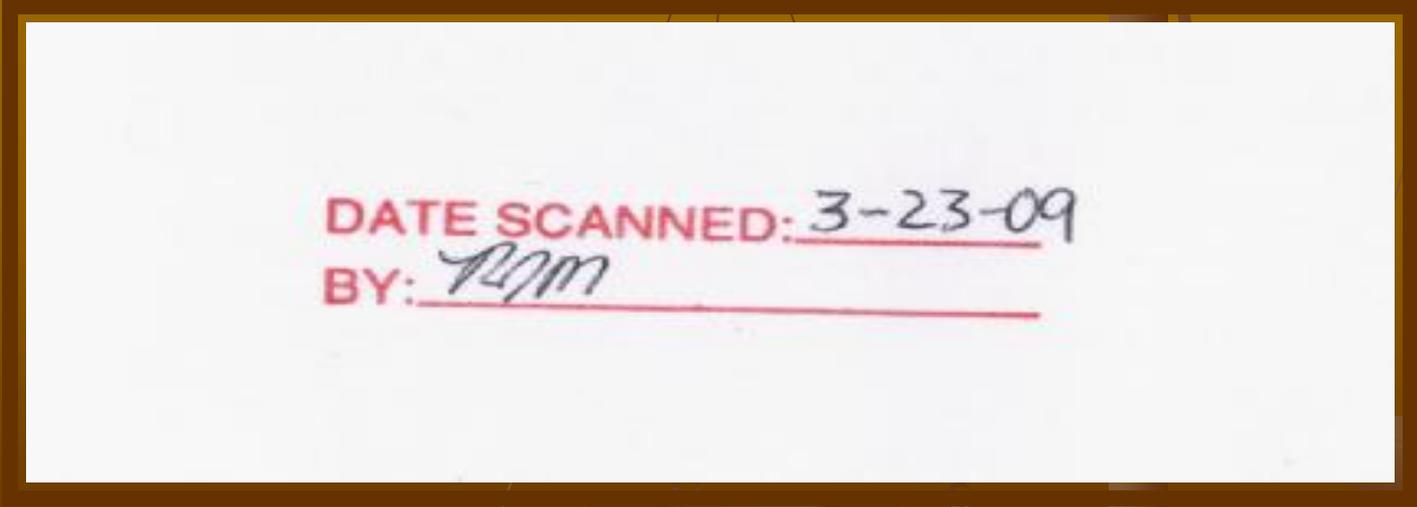


100% QUALITY ASSESSMENT
On the spot!



Signing your work.

Once a document is confirmed the technician will “stamp” each document scanned. The technician will initial and date accordingly.

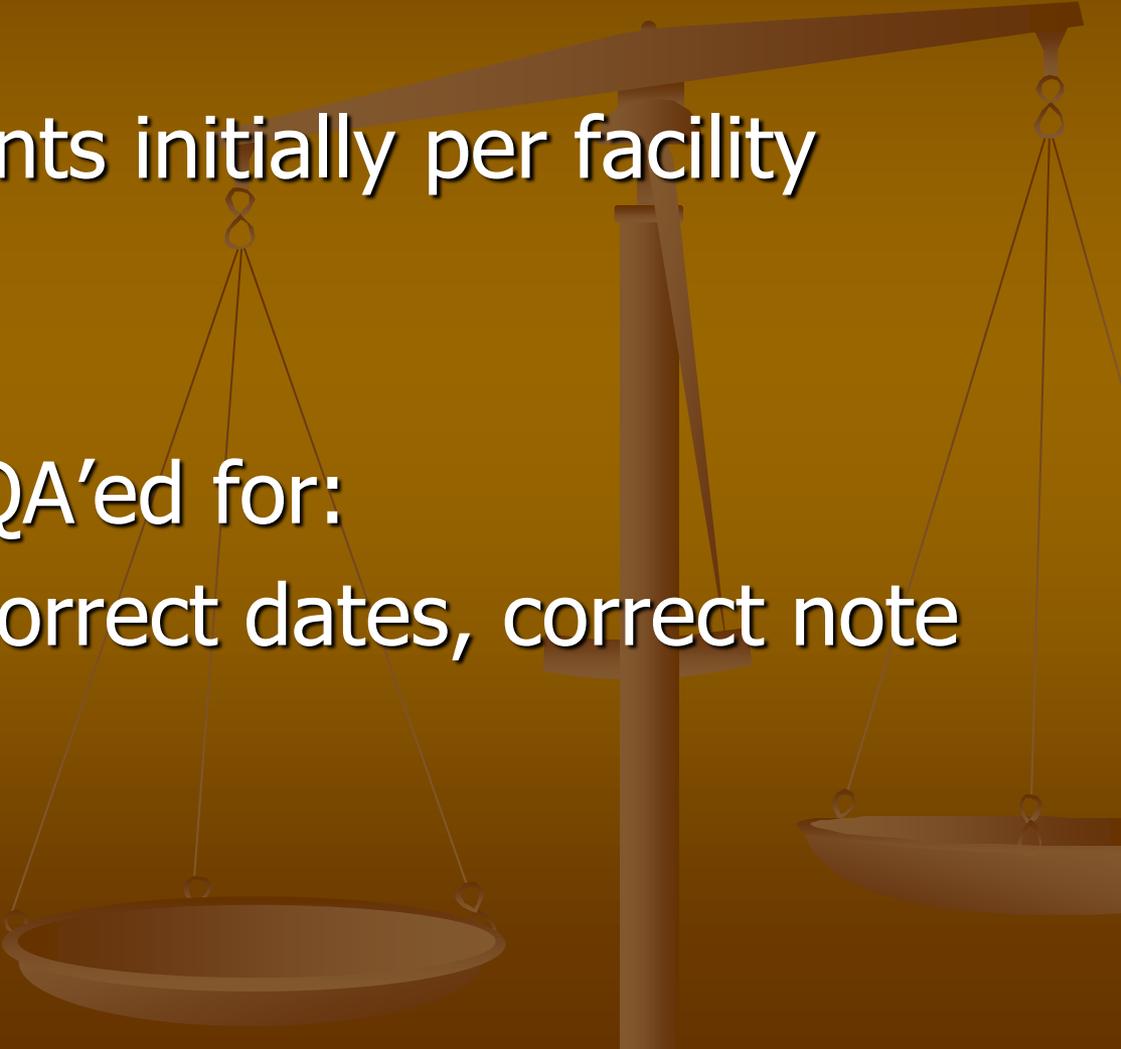


DATE SCANNED: 3-23-09
BY: *[signature]*

Final Quality Assessment



Quality assurance policy



- Two party check
- 100% of documents initially per facility policy

Each document is QA'ed for:

- Correct patient, correct dates, correct note title, legibility.
- Corrective Action

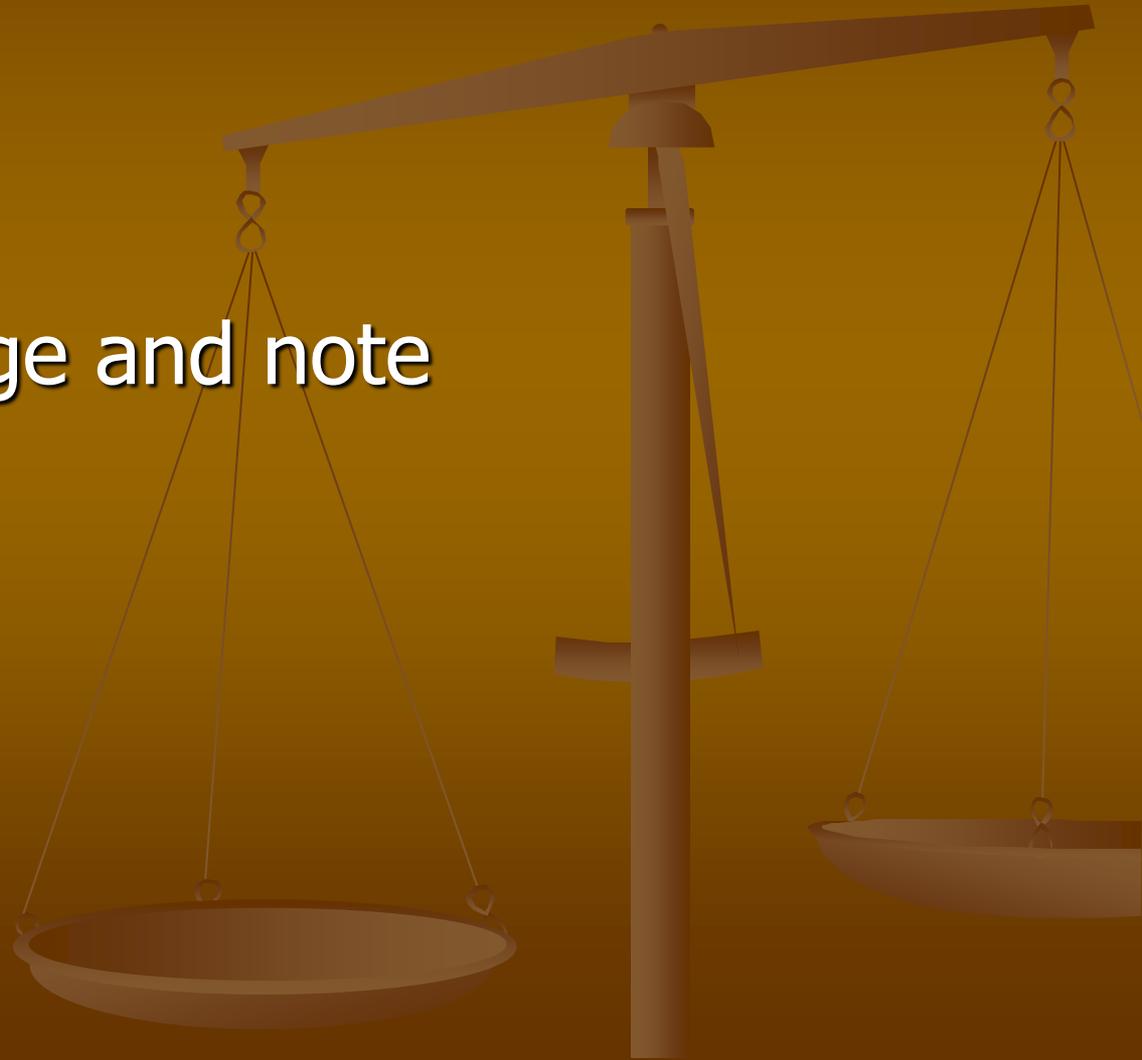
Approval

When an item is approved for physical filing the qualifying technician will initial and date, next to the scanning technician as shown below.

DATE SCANNED: 3-23-09
BY: PLM / QA ✓ BOB 3/23/09

ERRORS

- QA forms
- Addendums
- HIM
- Deletion of image and note



Record Retention

- Internal Documents
- External Documents
- Scan and Shred
- Federal Facilities and NARA



Thank you all!



Contact information

Contact information

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