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
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”.
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.
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
Routine Screening

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

1. Patient checks in
2. Patient taken to exam room
3. Collect patient vitals and document in EHR
4. Does pt meet screening criteria?
   - No: Stop
   - Yes: Complete screening and document in EHR
5. Intervention needed?
   - Yes: BH staff meets with patient
     - Is follow-up needed?
       - Yes: Appointment scheduled
       - No: Provider completes visit and documents in EHR
       - Patient leaves
   - No: Provider completes visit and documents in EHR
     - Patient leaves
Immunizations

Adult Immunization Workflow

1. Review patient list
2. Patient visits clinic
3. Immunized elsewhere? (Yes/No)
   - Yes: Immunization documented in EHR
   - No: Review immunization forecast in EHR
     - PI consents to immunization (Yes/No)
       - Yes: Immunization administered
         - Immunization documented in EHR
           - Immunization record printed and given to patient
       - No: Provider discusses risks/benefits
         - PI refusal documented in EHR
Colorectal Cancer Screening

- Patient visits clinic
  - Pt meets screening criteria?
    - No → Stop
    - Yes → Review pt record
  - Screening completed?
    - Yes → Document in EHR
    - No → Nursing provides supplies and explains process
      - Provider reinforces need
      - Pt completes test?
        - No → Follow-up with patient
        - Yes → Results received?
          - No → Contact lab for results
          - Yes → Normal result?
            - No → Results documented in EHR → Patient notified of need for follow-up
            - Yes → Patient notified and results documented in EHR
Mammograms
Medication Management

Medication Reconciliation Workflow

1. MA/LVN Prints Medication Sheet
2. Patient Roomed
3. Vitals Checked and Recorded in RPMS EHR
4. MA/LVN Reviews Medication Sheet with Patient
5. Does the Patient Take Outside Medications?
   - Yes: MA/LVN Obtains Outside Medications List from Patient
   - No: MA/LVN Updates Medication Tab in RPMS-EHR
6. MA/LVN Enters Education in RPMS EHR and Adds Provider as Co-Signer
7. Provider Reviews Medications with Patient
8. Is list missing medications?
   - Yes: Provider Enters Additional Medications
   - No: Provider Signs Medication Note
Referrals

Patient Referral Workflow

Provider identifies need and creates electronic referral

Is consultation emergent?

No

Is authorization required?

No

Referral and supporting documentation to vendor

Appointment scheduled (Patient or Social Services)

Appointment added to HIS by SOMEONE

Does patient need appointment?

Yes

Consultant seen by consultant

Consultant claim received

Consultant claim approved

Patient seen as needed

No

Consult report transmitted

Contract Care pays
keeps/losses referral

Patient seen as needed

Provider sends consult report to HHM

Consult report scanned

Social Services submits referral and documentation to insurance

Is referral approved?

No

Is additional information needed?

Yes

Yes