Electronic Health Record (EHR) For Health Information Management (HIM) Key Topics For New Users

Claremore Indian Hospital

Claremore Oklahoma

Key Problem Areas for HIM

- Electronic Record Analysis
- Documentation Issues
- Electronic Coding Environment

Electronic Record Analysis Administrative Issues

- Define chart completion time frame for electronic records in Medical Staff Rules and Regulations
- Must have administrative support to enforce chart completion time frames

Electronic Chart Analysis Staffing Issues

- Super EHR users at the point of care
- HIM Analysis Staff: As paper chart usage decreases, convert File Room staff to do electronic chart analysis
- Train all staff to be alert for and report documentation issues
- Deficiency reports must be worked daily to keep up–missing notes, unsigned notes, etc.

Analysis Function

- Becomes increasingly important as you transition from paper to electronic
- Staff are learning new processes–more room for error during learning curve
- Hybrid charts–documenting in two separate places–documentation must match
- EHR myth–legibility problems will go away with electronic documentation

Policy and Procedure (P&P) for Correcting EHR Errors

- Define who can correct errors
- Document reason for correction clearly for legal purposes
- Define visit lock time frame
- Define policy for retracting notes–Privacy Act Vs. Administrative Retraction

Notifying Providers of Deficiencies

- EHR Notification Function
- TIUM Reports
- Face-To-Face

Tracking of Deficiencies

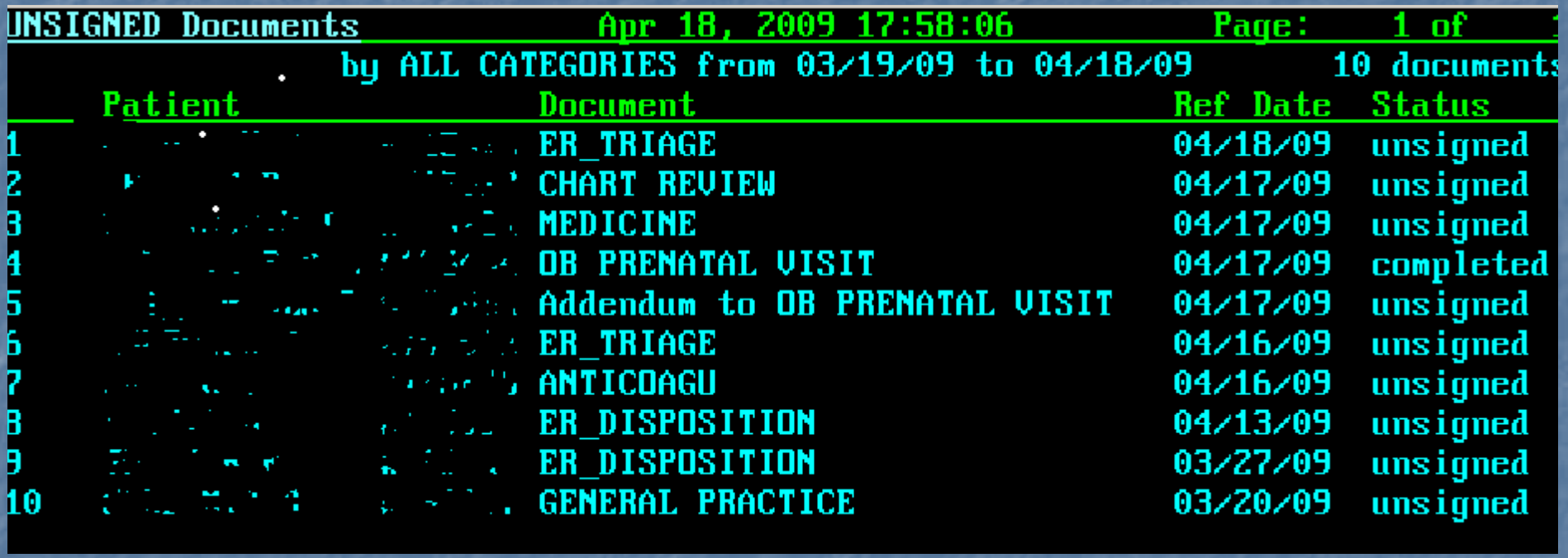
- EHR Notifications eventually roll off
- RPMS only tracks Inpatient, Day Surgery, Observation deficiencies
- Need for outpatient chart tracking system within RPMS is urgent

SPECIFIC TYPES OF ERRORS

Unsigned Notes

- Set mandatory notifications to Yes for unsigned notes
- Get administrative support to enforce/reward daily completion of progress notes
- Do not allow delayed signing of notes just to document laboratory results
- Unsigned notes cannot be viewed by others
- Define P&P regarding “signing for others”
- Run SSD report daily and hand-deliver reports to providers

SSD Report for Unsigned Progress Notes



UNSIGNED Documents Apr 18, 2009 17:58:06 Page: 1 of 1

by ALL CATEGORIES from 03/19/09 to 04/18/09 10 documents

	Patient	Document	Ref Date	Status
1		ER_TRIAGE	04/18/09	unsigned
2		CHART REVIEW	04/17/09	unsigned
3		MEDICINE	04/17/09	unsigned
4		OB PRENATAL VISIT	04/17/09	completed
5		Addendum to OB PRENATAL VISIT	04/17/09	unsigned
6		ER_TRIAGE	04/16/09	unsigned
7		ANTICOAGU	04/16/09	unsigned
8		ER_DISPOSITION	04/13/09	unsigned
9		ER_DISPOSITION	03/27/09	unsigned
10		GENERAL PRACTICE	03/20/09	unsigned

Missing Notes/POVs

- Use VGEN Report to identify visits that have been checked in/out, but have no POV or progress note.

PI REPORT FOR MISSING POV'S OR PROGRESS NOTES — Page 1

HRN	VST DATE&TIME	APPT DATE&TIME	CHECK OUT DATE&T	HOSP LOC	PROVIDER	ICD DX NARRAT	TIU NOTES
CLXXXXXX	04/18/09 04:25	04/18/09 04:25	04/18/09 07:25	OB TRIAGE	BAEHLER,EL	--	--
CLXXXXXX	04/18/09 00:31	04/18/09 00:31	04/18/09 03:42	EMERGENCY	STOPP,HARO	UNCODED DIAGN	ER_TRIAGE ER_DISPOSIT
CLXXXXXX	04/18/09 08:26	04/18/09 08:30	04/18/09 09:32	CHF	MURRAY,TIM	CONGESTIVE HE	NUR_TRIAGE PHAR CHF CL