Principles for the Use of the Ambulatory EMR

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Summary

An Electronic Health Record (EHR):

1. Provides tools to improve patient care
2. Facilitates communication
3. Provides safety and consistency to patients

Areas of importance:

- Problem list – Active and resolved problems versus past medical/surgical history
- Medication list – Active/historical, reconciled
- Allergies – Up to date and reaction noted
- Progress notes – Less is more, short, concise, accurate
- FYI Activity Flags – Appropriate
- MyChart
Introduction to the Electronic Health Record

- Shared tool
- Impacts quality of care
- Opportunity to collect and share data for population health improvement, disease surveillance and research.
- Therefore, to maximize benefit to all, a common set of practice principles are set forth.
- Principles are meant to define use of the EHR.
- Principles create a platform for common understanding.
- All members of medical staff are expected to demonstrate high level of professionalism and professional courtesy by observing and complying with principles of use.
General Principles

I. Ownership

Maintenance of the shared record is the responsibility of all providers contributing to each chart. Primary responsibility for chart maintenance belongs to the primary care physician and co-managing specialists.

Any provider caring for a given patient has a responsibility to contribute to chart maintenance relating to their care.

Remember, the information ultimately belongs to the patient.

II. Completion of Records

Access to a comprehensive record is dependent on complete, timely documentation. Documentation being available immediately in the record facilitates safe and meaningful encounters for the patient especially in urgent or emergent situations such as urgent specialty care, emergency department visits, admissions, and acute illnesses.

III. Respect for Other Providers Documentation

Changes to entries are appropriate when the entries are updated – such as refining a diagnosis, removing outdated or erroneous information or changing data not consistent with guidelines. Providers are responsible for confirming information entered by ancillary staff, students or house staff such as problem list entries, PMH, PSH, SH, FH, medication list and allergies.
Specific Guidelines Problem List: General

- Primary problems for the individual patient.
- Important for continuity of care, as well as, billing and coding functions
- Triggers Best Practice Alerts.
- All providers (PCP, specialists, covering physicians) are responsible to manage and update.
- New problems should be added by the clinician diagnosing or refining the diagnosis. Use the greatest degree of specificity available.
- Problems should be added or updated by the clinician reviewing available outside documentation.

Table 1: Desirable Items to Include:

<table>
<thead>
<tr>
<th>Appropriate Content for Problem List</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic medical problems requiring continued treatment, screening or monitoring.</td>
<td>Type 2 diabetes, essential hypertension, renal insufficiency, developmental delay</td>
</tr>
<tr>
<td>Recurring acute medical problems requiring evaluation or treatment.</td>
<td>Recurrent UTIs, recurrent shoulder dislocation</td>
</tr>
<tr>
<td>Problems requiring the prescription of scheduled or PRN medications chronically.</td>
<td>Anxiety, migraine, sciatica, SBE prophylaxis candidate</td>
</tr>
<tr>
<td>Problems requiring laboratory testing for monitoring.</td>
<td>Thyroid disease, anticoagulant long-term use</td>
</tr>
<tr>
<td>Acute symptoms while under active evaluation for diagnosis.</td>
<td>Abdominal pain, low back pain, changing skin lesion</td>
</tr>
<tr>
<td>Active or relapsing chemical dependency or abuse.</td>
<td>Tobacco abuse, narcotic dependence</td>
</tr>
<tr>
<td>Family history of disease that conveys a significant health risk upon the patient.</td>
<td>Family history of BRCA gene positive, family history of Huntington’s Disease</td>
</tr>
<tr>
<td>Chronic mental health disease.</td>
<td>Depression, bipolar disorder</td>
</tr>
<tr>
<td>Positive screening tests that impact continuing care or disease risk.</td>
<td>Abnormal PAP, PSA or PPD</td>
</tr>
</tbody>
</table>
Table 2: Items to Exclude

<table>
<thead>
<tr>
<th>Inappropriate Content for Problem List</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inactive or historical medical problems and completed surgeries.</td>
<td>Meningitis, appendectomy</td>
</tr>
<tr>
<td>Minor, self-limited illnesses or complaints.</td>
<td>URI, rash</td>
</tr>
<tr>
<td>Non-problems.</td>
<td>Physical exam, vaccination, counseling</td>
</tr>
<tr>
<td>Family history of limited or no significant health risk to the patient.</td>
<td>Family history of appendectomy</td>
</tr>
<tr>
<td>Screening study diagnosis.</td>
<td>Screening mammogram</td>
</tr>
<tr>
<td>Symptoms, when a diagnosis exists.</td>
<td>Cough when asthma is present</td>
</tr>
<tr>
<td>General diagnosis, when a specific one exists.</td>
<td>Sciatica when herniated lumbar disc is present</td>
</tr>
</tbody>
</table>

**Problem List: Maintenance**

- Review at each encounter.
- Remove inactive problems by resolving them – “Resolved” button.
- Erroneous problems should be deleted – “Delete” button.
- Surgical problems should be resolved when surgical problem is corrected and post op care is completed “Resolved” button.
- Procedures and results should be in past surgical history not with the problem on problem list. For example, problem list includes colon polyps but last colonoscopy is in PSH (this would also appear in Health Maintenance).
- Update and refine problems as more specific diagnoses are made.
- Symptoms placed on problem list temporarily should be replaced by most refined diagnosis or resolved as appropriate.
- Note: Deleted items remain recoverable but are not visible
Specific Guidelines: Past Medical and Surgical History

- Comprehensive catalog of all significant active and historical medical problems, past procedures, and surgeries.
- Complete and specific documentation including dates and comments should be included whenever possible.
- Significant active problems from problem list should also be documented here. (Use button to synchronize).
- Avoid cluttering history with self limited, temporary problems or symptoms, inconsequential problems, remote historical problems without continued importance, family or social history.

Specific Guidelines: Medication List

- All clinicians are expected to review at each encounter and update
- Key to safety and avoidance of medication errors
- Clinicians are responsible to review entries made by authorized support staff or house staff.
- Accuracy of medication list is dependent on addition or updating of active medications and removal of inactive or temporary medications with documentation of the specific reason for removal of the medication.
- Use of an “end date” for short-term medications will facilitate removal of short-term medications.
- Indicate chronic long-term medications by use of the “push pin.”
- Remove duplicate entries whenever identified.
- All prescriptions should be done electronically so the information is captured, interaction and allergy checking is complete and refills are facilitated.
- Any medication the patient is taking should be entered in the medication list even if prescribed by a non-University physician.
- All PRN medications (i.e. available for use at intervals), chronic over-the-counter medications, vitamins and supplements and homeopathic remedies should be documented.
- Associating diagnoses with medications is highly recommended to clarify intended use, facilitate refills and add to the completeness of the problem oriented charting data for a given problem.
- NOTE: Short-term over-the-counter medications such as cold medicines should be documented in the note, not on the medication list.
Specific Guidelines: Allergies

- Patient Safety requires that allergies be current, complete and accurate
- Document only allergies, reactions and intolerances on this list
- Enter the specific drug name and the reaction whenever possible.
- Multiple entries of drugs within the same class may be better represented by entering the drug class. For example, enter “Penicillins” instead of individual entries for amoxicillin, dicloxacillian and augmentin.
- Always note the allergy severity to categorize the nature of the reaction in the appropriate field (serious, unknown, or side effect). Enter other specific details if known.
- Environmental allergies should be documented in the problem list not in Allergies section. (This includes hymenoptera.)
- Allergic reaction to serum used to treat environmental allergies does belong in allergies activity (e.g. hymenoptera extract).

Specific Guidelines: Electronic Notes

- Progress notes for visit documentation should contain sufficient detail to permit continuity of care, identify problems addressed, reflect changes in treatment or condition, and note results of evaluation or treatment.
- Be concise – don’t bury the key information in extraneous data contained elsewhere in the record. If the data is not pertinent to decision making, don’t repeat it. For example, “lab data renewed and normal” is preferred to a long list of normal values. This includes when dictating into the note.
- Extent of documentation should match complexity of the problem and required decision making. Review each templated note to be sure it truly reflects services performed.
- Copy previous (“Copy Prev”) – Epic-based function that brings in previous documentation that may not be appropriate for current visit. However, it does refresh any Smart Links used in the original note so certain things like vital signs will be updated. Use extreme caution and care in proof-reading and editing any Copy Prev note.
- Copy and paste: This is generally discouraged in visit documentation. It does not refresh Smart Links so old weights or vital signs will not be updated. Extreme care in editing is required!
- Dot Phrases should be used with care and edited appropriately to the individual patient.
Specific Guidelines: Smart Links

- Any Smart Link included in a template should be carefully monitored to be sure correct data is brought into the note.
- These do not update when using Copy/Paste.

Specific Guidelines: Correct Note Type

- Select correct note type when generating a note in Epic.
- Note types file differently and will be difficult to find if the incorrect type is used.

Table 3  **Additional note types may be added as appropriate**

<table>
<thead>
<tr>
<th>Ambulatory Note Type</th>
<th>Select This Note Type In Epic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>To enter historical data outside of a visit</td>
</tr>
<tr>
<td>Care Plan Oversight</td>
<td>For review of outside care plan and billing</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>Endoscopy center procedure encounters</td>
</tr>
<tr>
<td>Home</td>
<td>Home visits</td>
</tr>
<tr>
<td>Letter</td>
<td>Letter out not related to visit</td>
</tr>
<tr>
<td>NST</td>
<td>OB non-stress test not associated with visit</td>
</tr>
<tr>
<td>Nurse</td>
<td>Nurse visits</td>
</tr>
<tr>
<td>OB</td>
<td>OB visit (especially pregnancy episodes)</td>
</tr>
<tr>
<td>OccMed</td>
<td>Specific Occupational Medicine Clinic visit</td>
</tr>
<tr>
<td>Office</td>
<td>Standard office visit</td>
</tr>
<tr>
<td>Orders Only</td>
<td>Orders not associated with visit</td>
</tr>
<tr>
<td>Outside Records</td>
<td>Used by scanning for records scanned</td>
</tr>
<tr>
<td>Patient Education</td>
<td>Specific to educators</td>
</tr>
<tr>
<td>Patient E-Mail</td>
<td>To copy/paste email and response</td>
</tr>
<tr>
<td>Pre-Visit Planning</td>
<td>For documentation of contact and orders</td>
</tr>
<tr>
<td>Psychology</td>
<td>Specific to psychology consult encounters</td>
</tr>
<tr>
<td>Refill</td>
<td>Not associated with visit</td>
</tr>
<tr>
<td>Telephone</td>
<td>To document telephone messages</td>
</tr>
<tr>
<td>Vision</td>
<td>Optometry visits</td>
</tr>
</tbody>
</table>
Specific Guidelines: FYI Activity

- Data entered in FYI is available each time the chart is opened regardless of encounter type.
- Users in all areas may have access to this data.
- FYI is a communication tool for registration, financial, release of information, and clinical staff.
- Nine categories are currently built into FYI.
- DO NOT use this as a general communication tool for clinical information.
- Deactivate flags when no longer appropriate (e.g. patient no longer on research protocol).
- Deactivated flags are always part of the medical record although hidden.

Specific Guidelines: PCP Designation

- A limited number of providers in the organization are able to be designated as PCP.
- It is important that the PCP be updated and corrected.
- Any provider not on the designated PCP list can request to be added for specific cases where a specialist serves as the PCP for a given patient.

Specific Guidelines: MyChart

- Most routine labs are automatically released at 72 hours. Radiology and Pathology results will be auto released in 7 days from final report.
- Life-altering (e.g. Mental illness), life-threatening (e.g. Cancer, HIV) laboratory results and diagnoses are manually released only.
- Proxy access can be established for family members.
- Once a child reaches 12 years of age, parental access to child’s chart is removed.
- Parents may view immunizations only in adolescent’s chart (12 – 18).
- Once a patient requests an account and activates it, the provider will receive a request to release information to the chart. This should be accomplished in 3 working days.
- Patient messaging to the provider and requests for appointments are handled just as phone and appointment calls are handled now.
Specific guidelines In-basket

- Distribution of results to providers will depend on the ability to flag abnormal results. Thus, all radiology and pathology results will be routed to the ordering/authorizing provider in-basket as they cannot be flagged to note abnormal results. Abnormal laboratory results will be routed to the ordering/authorizing provider in-basket. Normal laboratory results can be routed to a staff pool to be handled by protocol.

- Laboratory, radiology and other routine test results should be reviewed and signed within 48 hours after the report is received. A result note should be created for each lab so that the trail of actions is obvious to the next caretaker.

- MyChart contact, Telephone contact, or a letter to the patient should be completed within 7 days for normal results (normal labs will automatically release to My Chart in 72 hours).

- **Critical results** should be reviewed and reported to the patient immediately with appropriate actions recommended as the laboratory value warrants. The contact with the patient should be documented, timed and dated. It is understood that a critical value by the laboratory guidelines may not reflect a true critical value for an individual patient. Documentation should be made around expected abnormal values.

- All phone messages should have a response within one business day. Urgent phone messages should be acted upon immediately.

- Results received on paper (if not available electronically within the system) should be signed and sent for scanning.

- Refill requests should be acted upon within 3 business days for routine refills. A refill encounter should be created for medications refilled outside the system, noted to be a telephone refill and documented on the medication list.

- Forms and letters requested by the patient should be completed within 7 days.
Specific Guidelines Order Entry

It is University of Utah Health Care Policy that wherever computerized order entry is available, it is the standard and expected for all orders.

This includes orders for laboratory, all medications, radiology, referrals, DME, consults, procedures and all other orders.

Computerized order entry will contribute to patient safety and Meaningful Use. Medication orders allow for allergy and interaction checking.