Catholic Health

Standards of Electronic Health Record (EHR) Proficiency, Usage, and Data Exchange

1. All providers who care for patients in the hospital will be expected to be trained in – and capable of using well – the EHR of Catholic Health.

2. EHR proficiency includes being able to use well all core functions and features needed to take care of patients. It also encompasses being able to use the EHR efficiently and to take all necessary steps to try and reduce the proportion of time spent in electronic documentation compared to direct patient care.

3. Given the unique and complex difficulties inherent in using EHR's effectively, it is expected that all providers in the Department of Medicine will avail themselves of appropriate training and resources that may be available, both formally and informally, to improve the skill and efficiency of their EHR documentation. All providers should also view themselves as mentors and readily and regularly share efficiencies that they have developed or identified with other providers.

4. Given the complexity of electronics, it is expected that all providers will continuously evaluate their efficiency and identify problems and inefficiencies and seek additional assistance to reduce their documentation time. In addition, all providers will participate as indicated or advised in any programs that are established to measure, improve or enhance EHR documentation efficiency.

5. All physicians and non-physician providers who care for patients in the hospital will be expected to have access to and use all appropriate external information resources that are available to them. These resources can include HEALTHeLink, Surescripts prescription data, the "old records" of the hospital's current and prior EHR, as well as external EHR's such as those in ambulatory settings and other hospitals for which they may have both access and permission to obtain appropriate information. Although not all available data resources need to be evaluated with every patient, it is the responsibility of the provider to ascertain when such access would be beneficial, and to utilize such resources appropriately and timely when it will benefit patient care.

6. It is not considered to be good care or a standard of care when information that is available from internal or external resources is omitted from the patient medical record in situations where such information could be beneficial to patient care. This includes information from the medical record of the outpatient practice (s) of the patient by contacting the provider of the practice directly or through linkage into the outpatient EHR.

7. Providers who care for patients in the hospital will often provide care remotely such as needing to give orders. In such situations it is usually/always helpful to be familiar with data and information available within the EHR. For that reason, all such providers are expected to have remote secure access to the EHR available to them, and to use that access whenever it is appropriate and in the best interests of patient care.

8. Members of the medical staff in the department who do not treat patients in the hospital are encouraged to have remote access and use the hospital EHR. Such usage can include viewing information about patients for whom they have appropriate access, as well as creating progress notes on their patients where appropriate. Such noted can be created to provide information to hospital providers, document conversations and discussions with patients or

patient relatives, document “PCP visits” to the hospital to see their patients, or other similar situations where documentation would be constructive.