HOUSTON Methodist LEADING MEDICINE

Houston Methodist Epic Access Policy

Subject:
Epic EHR Access & Training Policy

Applies to:
All HM Entities including
- HM Specialty Physician Group
- HM Primary Care Group

Originating Area:
HM Chief Medical Officers
HM Chief Quality Officers
HM Chief Medical Information Officer
HM SPG/PCG Chief Quality Officer/Medical Information Officer

Effective Date:
January 1, 2016

Date Revised/Reviewed:
January 1, 2016

Target Review Date:
January 1, 2018

POLICY STATEMENT

This policy is the Houston Methodist System positon on Epic EHR Access and Training Standards for all providers rendering clinical or administrative activity.

PATIENT SAFETY & QUALITY STATEMENT

At Houston Methodist, the integrated electronic health record (Epic) will continue to lead medicine in a patient-centric environment that optimizes best care practices and drives consistent clinical and financial outcomes. Use of the Epic EHR is essential to the continuous quality improvement program at Houston Methodist. Our patients and clinicians will be able to engage and collaborate through more diverse technologies to enhance the patient experience and promote safety and quality.

AUDIENCE

All Providers

IMPLEMENTATION

Epic EHR access is required for direct patient care at all HM facilities and affiliated clinics. For Epic EHR access, training is required and will be conducted by the identified HM Epic Training Team with a minimum proficiency as set forth by HM standards.

ROLES

For the purposes of this policy, “providers” include all physicians, residents, fellows, mid-levels (PA, NP) and medical or mid-level students providing patient care at Houston Methodist.

POLICY

Any provider participating in direct clinical care at Houston Methodist and/or affiliated clinics must pass a proficiency threshold as set forth by Houston Methodist.
Direct clinical care includes:

- Admitting patients
- Conducting patient care in affiliated clinics
- Performing any inpatient or outpatient procedures
- Rendering inpatient services
- Promoting safe transitions of care

Adjunct or temporary faculty members of Houston Methodist who provide direct clinical care must use the Epic EHR system for provider order entry and documentation.

All providers will follow the HM commonly accepted principles for use of the electronic health record. This would include the elements listed below and outlined in the Houston Methodist Provider Chart Fundamentals and Expectations Document (Appendix A):

- Computerized Provider Order Entry
- Documentation Framework Guidelines
- General Documentation Principles
- Timely response to In Basket Communication
- Problem list management

Providers must log on to Epic using their own username and password. Use of another provider's username is strictly prohibited.

DEMONSTRATING PROFICIENCY IN THE EHR

Houston Methodist will grant security access to the EHR only to providers who have followed the established training guidelines which coincide with their level of clinical care.
Most providers will require full access. The policy specifies as to how prior Epic use affects training requirements and specifics around which functionality is needed.

All providers must demonstrate proficiency by an exam specific to the level of access required.

COMPLIANCE

If during training a provider is identified by the Epic Project team or Houston Methodist leadership as not becoming proficient with the system despite targeted support, this finding will be reported to the Office of the CMIO for mitigation.

If at any time a provider is not compliant with the chart etiquette requirements, this finding will also be reported to the Office of the CMIO.

If that Provider is an employee of the Houston Methodist Physician Organization the information will be transmitted to the appropriate Department Chair and/or CMIO. It is the responsibility of the CMIO to facilitate the resolution of the issue (counselling, training, specific accommodation, etc.) with the support of the Department Chair (if applicable) and the Epic project team. Failing this, the issue will be escalated to the P.O. Leadership (Compliance/Quality Committee and/or Board) for final resolution.

If that provider is a not an employee of the Houston Methodist Physician Organization the information will be transmitted to the appropriate Section Chief and CMIO. It is the responsibility of the CMIO to facilitate the resolution of the issue (counselling, training, specific accommodation, etc.) with the support of the Section Chief and the Epic project team. Failing this, the issue will be escalated to the senior physician leadership at each facility (CMO, CQO, and Chief of Staff). If necessary, senior leader will escalate to Medical Staff Committee for final resolution.

COUNCILS OR COMMITTEES REVIEWING OR APPROVING POLICY

Houston Methodist Medical Staff Physician Leadership Council
Houston Methodist Epic Clinical Practice Committee
Houston Methodist System Clinical Practice Committee
Houston Methodist PO EMR Steering Committee
CEO Council

AUTHORITATIVE REFERENCES

Not applicable

ATTACHMENTS

Houston Methodist Provider Chart Fundamentals and Expectations

NAME OF APPROVING EXECUTIVE: ROBERT A.PHILLIPS, MD, PhD, FACC
TITLE: HOUSTON METHODIST EVP, CMO
HOUSTON METHODIST SPECIALTY PHYSICIAN GROUP, PRESIDENT & CEO

_____ _____
Signature of Approving Executive Date Signed

Revision History As required by ISO9001, document the

Revision	Date	Changed by	Revision Summary
1	09/30/2015	Dr. Nicholas Desai, CMIO	VERSION 1.0

Houston Methodist

Provider Chart Fundamentals and Expectations

Table of Contents

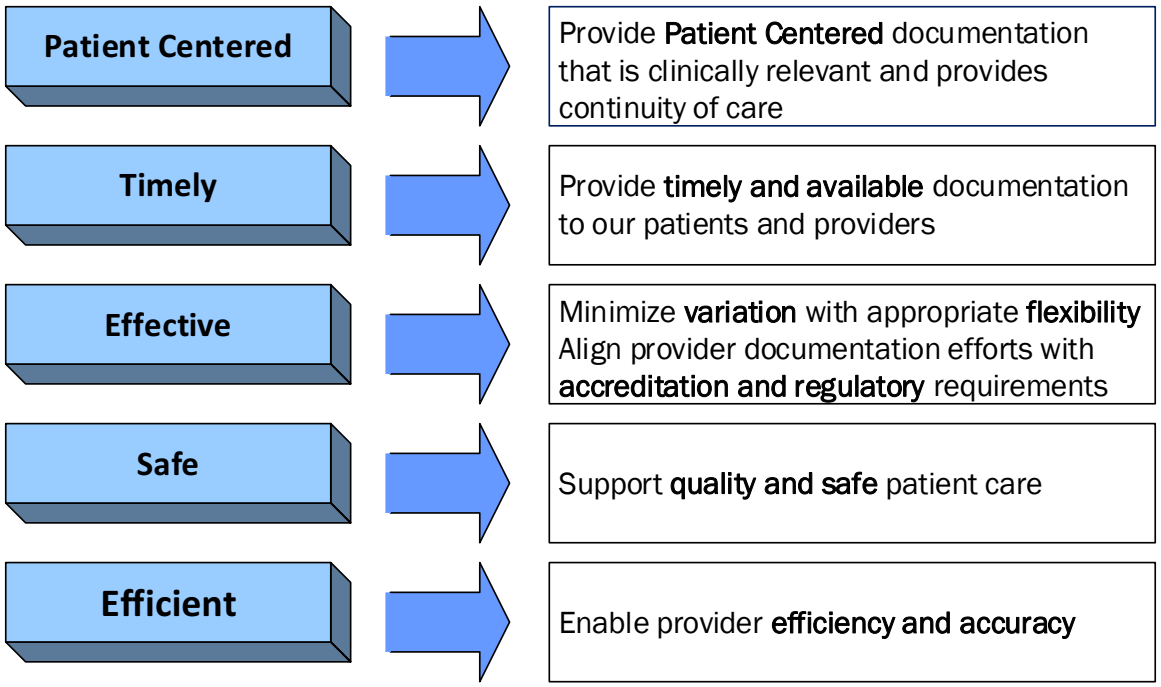
Introduction

Many providers and staff share the electronic health record (EHR) across the patient care continuum. As such, the EHR can improve quality, patient safety, efficiency, and both patient and provider satisfaction. However, in order to fully realize these benefits, it is essential that all providers observe a common set of practice principles when using the EHR. These practice principles are termed ***chart etiquette***.

Ownership of information contained within medical records belongs not to providers, but to patients. Maintenance of these shared records is the responsibility of all clinicians documenting in the EHR. All providers are responsible for contributing to the EHR maintenance as it relates to their care of the patient. Used properly, the Problem List and the other "patient level data" contained within the electronic chart will allow clincian to fully leverage the power of the EHR, improving patient care and their efficiency.

Guiding Principles

The following documentation guiding principles were defined and approved by a core group of Physician Champions and the Core Physician Documentation Workgroup participating in the Epic Project.



Clinical documentation serves many purposes in the modern healthcare environment. Medical record documentation has evolved from simple documentation of clinical events to an infrastructure that also supports clinical communication among healthcare professionals, clinical decision support, financial reporting and both legal and regulatory interactions. However, the overall goal of clinical documentation is to assure the quality of individual patient care, patient safety, and improved population health.

As such, healthcare providers at Houston Methodist will utilize the Epic electronic health record (EHR) to:

1. Create timely, legible, and accurate notes which are accessible anywhere.
2. Optimize the “readability” of both inpatient and ambulatory notes in the EHR.
3. Enhance patient care by highlighting important clinical information and diminishing “note-bloat” and clutter.
4. Improve communication between Houston Methodist providers and referring providers external to Houston Methodist.
5. Improve communication among health care providers internal to Houston Methodist.
6. Facilitate the evaluation and improvement of quality patient care, patient safety, and population health.
7. Meet the needs of hospital coding and professional billing.
8. Meet the compliance and regulatory documentation requirements of Houston Methodist.
9. Improve communication and education regarding best practices between attending physicians and trainees

There is a delicate balance between comprehensiveness and efficiency in the use of computerized provider documentation.

As our use of the Epic EHR evolves our expectation is that there will be gradual improvement in the efficacy of clinical documentation resulting in advancement of the overall vision of improving patient quality, safety, and health. Toward that end, clinical documentation should be multidisciplinary with each member of the health care team working at the “top of their license” to contribute to an efficient and efficacious documentation system that supports our patients’ health and well-being.

Documentation Tools

Epic supports multiple documentation tools. Standard keyboard typing and mouse entry is always an option when entering clinical data. SmartTools are components of the Epic software that allow for more rapid entry of text, templates, lists, forms, macros, and order sets. This enhances both documentation and ordering, as well as providing decision support. Traditional dictation used in specific parts of the medical record is discussed below and allows for using dictation in that portion of the medical record where a narrative approach makes sense, such as in the history of present illness. Voice recognition, also discussed below, provides for immediate incorporation of dictated narrative and can support some SmartTool efficiencies as well.

Your choice of the multiple data entry tools available to you depends both on your familiarity with all the tools and the context of the clinical situation you are in. You would choose different tools in a hospital setting as compared with an ambulatory setting. What tools you use and how you organize your support staff to contribute to documentation would differ in an orthopedic office with many shorter visits compared with your choices in a psychiatry office with longer visits and the need for detailed individual narratives. Epic provides a tool box of documentation techniques to meet your needs.

Progress Notes

The progress note is the communication tool for providers. The following are guidelines for best utilizing the Epic EHR as a shared chart.

Note Bloat

Modern electronic health records can provide dramatic improvements in speed and clarity in access to clinical information. However, if used improperly documentation tools in electronic health records can lead to lengthy, unreadable notes that confuse rather than enhance clinical communication. This phenomenon is called "note bloat".

Some of the causes of note bloat include:

1. Using SmartLinks that pull in too much information.
2. Copy Forward (see section below).
3. Uncertainty about billing and medicolegal requirements and erring on the side of "caution".
4. Meeting unrealistic educational demands and expectations by keeping "running stories" on daily progress notes or by using notes for reference on academic rounds.

Misunderstanding billing requirements is perhaps the largest contributor to note bloat. Only medically necessary services are billable, regardless of the detail in documentation. The volume of data in a note does not support billing at a higher level of service than the presentation requires. Electronic records may allow for easy entry of comprehensive review of systems and physical exams with a myriad of test data, however using these entry tools to document volumes of data for a patient with a minor illness does not allow for inappropriate and fraudulent "up-coding" for higher levels of service.

It is important to understand the documentation requirements for each level of service. Each ambulatory encounter consists of several sections in the "Rooming" activity such as allergies, medications, past medical/family/social history in addition to the "Note" activity. Making reference to this already collected and reviewed information either by a brief reference to it in the note and/or use of the "Mark as Reviewed" buttons in the "Rooming" activity indicates review of these sections. These do not have to be repeated in the "Note" activity unless there is a clinical reason to do so for emphasis or communication purposes. Failure to understand this concept frequently lengthens notes and decreases readability.

In both the inpatient and ambulatory setting incorporating into the note lab and radiology results not related to the medical necessity or context of the visit adds to "note bloat" without contributing to proper coding levels as mentioned above.

Remember that the progress note is a provider communication tool. It is important to strike a balance between too little and too much information. Too little information may impair patient care by excluding important items. Similarly, a voluminous note may impair patient care by burying the pertinent information to such an extent within the extraneous matter that it is not seen. For the most part, if data is already in the EHR and is not directly pertinent to decision making, it should not be included in the note specifically.

Templates

You are responsible for everything in your note. Using a comprehensive template for a brief visit may falsely indicate that you performed a complete Review of Systems or Physical Examination. Be sure to proofread each note generated by the use of a template to ensure that it is a **true representation of services performed**. All note templates must include the required elements denoted in **Appendix I.**

Copy Forward

Copy Forward is a popular Epic-based function used for documentation which can improve documentation efficiency. When using this function SmartLinks are automatically refreshed. However providers must recognize that it may bring in previous documentation that is incorrect or not appropriate for the current note. It is imperative to take extreme care in proofreading and making appropriate edits for every note that is created in using this function.

Indiscriminate or inappropriate use of copy forward of medical record documentation may lengthen notes, add unnecessary information, create inaccuracies, and make it time-consuming for others to quickly locate pertinent information. It may also degrade the quality of care and accuracy of data and negatively affect the integrity of the medical record.

While providers will have the ability to judiciously and responsibly "copy forward" previous note content from their own or other care-giver's notes, this ability is associated with certain hazards that the provider must recognize. Dangers of copy forward include:

1. The possibility of inaccurate or irrelevant information appearing in the current note.
2. Unnecessary clutter appearing in the current note in the form of redundant, outdated, or useless information.
3. Unnecessary laboratory, radiology and other results (e.g. 6 full complete blood count results from the last 24 hours).
4. The appearance of provider names in the note who are no longer providing care.
5. The appearance of diagnoses in the note which have been resolved.
6. Importing relative dates in the notes that convey inaccurate information ("today", "yesterday", etc.).

Consequently, when creating a note providers have the following responsibilities to ensure effective electronic documentation.

1. Providers are responsible for the total content of their signed documentation, whether the content is original, copied, pasted, imported, or reused. Once signed, notes are a permanent part of the legal medical record. While notes may be "addended", the signed, permanent note may be made available in multiple clinical and non-clinical settings including legal, billing, regulatory, ancillary, outside record requests and personal health records.

2. Providers are required to document in compliance with all federal, state, and local laws and Medical Staff Rules and Regulations.
3. Providers' notes should be succinct recapitulation of a unique episode of care.
4. Providers must carefully review and correct automated documentation elements such as SmartPhrases and Note Writer Macros to assure that all documented elements of care were actually performed. Failure to do so could constitute fraudulent documentation.
5. When providers "copy forward" previous note content they are responsible for producing a concise, accurate, note absent of inaccuracies, redundancy and clutter.

6. Providers are prohibited from using HIM specified “Do not use” abbreviations.
7. Only medically necessary services should be billed, regardless of the detail in documentation. When using electronic techniques to improve documentation efficiency such as “copy forward”, care must be used to choose billing codes that are based on medical necessity not volume of medical data brought forward.
8. Information entered using the Epic Copy Forward function from a previous note should include only that information that would be re-entered verbatim (e.g., past surgical history) and all remaining information should be newly created or updated with the current information and assessment.
9. Providers are responsible for clearly identifying who performed each service documented within the note. When entering or copying forward patient data into the medical record that the provider did not personally take or test, the provider must attribute the information to the person who did.
10. Copied information must be attributed to the original source/provider, and reference the date of the original note. Example: “Below is a copy of ED HPI dated….”
11. It is inappropriate to copy forward verbatim the following documentation:
    a. 24 hour summary
    b. Assessment and Plan of another provider – these must be updated daily ensuring that they address all significant problems and issues
    c. Physical Exam of another provider
    d. Erroneous data
    e. Attending professional billing code information
    f. Excessive laboratory or other testing results
    g. Inaccurate diagnoses, problems or allergies
12. Providers are responsible for citing and summarizing applicable lab data, pathology, and radiology reports rather than copying such reports in their entirety into the note. Providers may reference such information documented elsewhere in the medical record. The inclusion of long lists of auto-populated laboratory values, vital signs, and radiology reports such as by using Epic SmartLinks is highly discouraged. The note should include only those data which support the impression and plan.
13. Attending physicians are encouraged to carefully review each note for content and to provide feedback to trainees on critical thinking and note quality.

Adherence to these requirements will be monitored by each entity’s medical records committee. Periodic analysis reports will be made available to each entity’s Medical Staff Committee, Compliance Office, Service Leaders or Medical Directors, as appropriate. Training on best practices for provider documentation including use of Copy Forward will become part of the Houston Methodist Epic on-boarding training curriculum for all users who document clinical information.

Copy and Paste

Copy and Paste is a Windows-based function that acts differently than does Copy Forward, and its use is **highly discouraged**. The most important difference is that it will not refresh Smart Links (so, for example, it could bring yesterday's vital signs into today's note). As with Copy Previous, the use of Copy and Paste makes it imperative to take extreme care in proofreading and making appropriate edits for every note created in this way.

Dictation

A hybrid approach to note documentation allows clinicians to dictate only those parts of the note that are better suited to a freestyle format while retaining the use of Epic's documentation tools (SmartTools) for other sections within a note.

Epic tools that clinicians may use for note documentation include "SmartTools" such as SmartTexts, SmartPhrases and NoteWriter. Sections best documented with these tools include patient demographics such as age or sex, relevant meds, allergies, relevant past family or social history, review of systems and the physical exam. A providers may find that that these tools, in combination with limited free text, will provide for all of his documentation needs. On the other hand, the provider may decide that a complex narrative involved in documentation of the history of present illness or assessment and plan may be better suited to dictation than keyboard entry.

When dictation is necessary, the combination of dictating part of the note and using Epic's documentation tools for other parts is preferred over full dictation of a note. This hybrid approach acknowledges the entry of structured data into the note from other parts of the EHR thereby avoiding duplicate data entry. For example, medications, allergies and diagnoses entered and reviewed at a clinic visit through structured data entry tools do not need to be dictated back into a note.

Dictation is available through two main technologies at Houston Methodist. Partial dictation using Nuance will be allowed for appropriate areas in the chart. Typically, physicians dictate with a pointer in the appropriate chart location. The voice file is sent to Nuance which then sends back the transcribed section and the dictated section files into the note at a placeholder hyperlink. The time lag between dictation and final signature by the physician is usually measured in days. The voice file continues to be available in the note until the transcription is accepted. Voice recognition using Dragon Medical (also owned by Nuance) is also available for use in Epic. When using voice recognition technology dictated words immediately appear in Epic.

Best practices for clinical documentation will vary by note type. For instance, a daily inpatient progress note is usually more quickly entered using SmartTools. The discharge summary is ideal for the hybrid approach by using voice recognition or partial dictation to describe a complicated hospital course but SmartTools to pull in discharge meds and other sections.

Co-signature

The table below outlines the note co-signature matrix for providers using Epic at Houston Methodist. Epic has been configured to automatically support these requirements, which are in compliance with both local medical staff policies and the Texas Medical Board and Texas Board of Nursing rules.

Documentation - Cosign Required Matrix

	Notes-Cosign Required Matrix									
Provider Type/License	H&P	ED Provider Note	Progress Note	Consult Note	Operative Note	Procedure Note	Discharge Summary	Anesthesia Pre-Op	Anesthesia Post-Op	Brief Op Note
Attending Physician	No	No	No	No	No	No	No	No	No	No
Fellow	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Recommended
Resident	**Yes**	**Yes**	**Recommended**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Recommended**
Mid-levels (Physician Assistant, Nurse Practitioners), Clinical Nurse Specialist	**Yes**	**No**	**No**	**Yes**	**No**	**No**	**No**	**N/A**	**N/A**	**No**
Midwife	**Yes**	**No**	**No**	**No**	**No**	**No**	**No**	**N/A**	**N/A**	**No**
CRNA	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**No**	**No**	**N/A**
Independent Allied Health (Psychologists, Physicists, etc)	**N/A**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**
Registered Nurse	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LPN	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nursing Students	N/A	N/A	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medical Students (will use Medical Student note type that is excluded from LMR)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pharmacist	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A
Therapists-PT/OT/Speech	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A
Respiratory Therapists	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A
Therapy Students	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A
Speech Therapy Clinical Fellow	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A

Dietician	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A
Pharmacy Students	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A
Radiology Tech Students	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A
Social Worker	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A
Case Management	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A
Pastoral Care	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A
Physical Therapy Assistants	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A
Rounds Nurse	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A
Licensed Clinical Counselor (LPCC)	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A
Certified Surgical Technician (CST)	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A
Certified Ophthalmic Assistant (COA)	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A
Radiologic Technologist (RT)	N/A	N/A	No	No	N/A	N/A	N/A	N/A	N/A	N/A
	Legend:									
	Yes = Credentialed employee can document or perform the function but requires a countersignature (attestation) by another party									
	No = Credentialed employee can complete the documentation or function and does not require a countersignature									
	Recommended = Credentialed employee will have the option to send cosign IB message, but isn't required									
	N/A = Employee does not document the information or perform the function because 1) they have view-only access, 2) their workflow does not require them to perform the function									

Orders - Cosign Required Matrix

User Type	Venue (I/O/B)	Billing Provider	Medication Order Cosign Required	Procedure Order Cosign Required
Physician Assistant	Both	Yes	No	No
CRNA	Inpatient	Yes	No	No
Nurse Practitioner	Both	Yes	No	No
Midwife	Both	Yes	No	No

Teaching Physician Attestation

Teaching physicians who supervise resident physicians will have the following Houston Methodist approved attestation statements available through SmartPhrases.

Inpatient Attestation

Admitting Note: "I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care." Smartphrase Placeholder

Initial or Follow-up Visit: "I was present with the resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note." Smartphrase Placeholder

Follow-up Visit: I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident's note." Smartphrase Placeholder

Follow-up Visit: I saw and examined the patient. I agree with the resident's note except …. Smartphrase Placeholder

Follow-up Visit: "I saw the patient with the resident and agree with the resident's findings and plan." Smartphrase Placeholder

Smart Phrase name: Endoscopy – I was present for the entire viewing of this endoscopy.

Smart Phrase name: Single or other complex procedure- The key portion of this procedure was performed in my presence.

Smart Phrase name: Overlapping surgical or complex procedure – I was present and I participated during the critical and key portions of this procedure and Dr. *** was immediately available during the remainder of the procedure. I interpret the critical and key portions of this procedure to have been ***.

Smart Phrase name: Absent during opening or closing – I was present and I participated during the entire procedure except for the opening and/or closing which overlapped with the opening and/or closing of another case. The overlapping portions were non-key portions and I {remained/was not} immediately available. I interpret the critical and key portions of this procedure to have been ***. [Embed within the "was not" portion a follow-on smart text that says, "Dr. *** was assigned to be immediately available during the overlapping portions of these cases."]

PO Attestations

There should be three Smart Phrases for physician attestations at HM (**in red bold below**):

Smart Phrase name: ATTESTATION

- I performed the history and physical exam on the patient, discussed care and agree with the findings and plan.
    - I agree with the resident's note with the exception of: ***
- I saw the patient with the resident, discussed the case and agree with findings and plan.
    - I agree with the resident's note with the exception of: ***

Imaging and Diagnostics:
I personally reviewed the *** image(s) and agree with the resident's findings
I personally reviewed the *** and agree with the resident's interpretation with no exceptions.
I personally reviewed the *** agree with the resident's interpretation with the exception of: ***

Minor procedures: I was present and supervised the entire procedure.
Major Procedures: I was present for the key portions of the procedure.
Key portions included: ***

Smart Phrase name: PCAttestation (nb: pc =Primary Care exception) ***synonyms should be attestation, exception, PC***

- I read the resident's note, discussed the case and agree with findings and plan (used ONLY with LOS 1-3)
- I performed the history and physical exam on the patient, discussed care and agree with the findings and plan.
    - I agree with the resident's note with the exception of: ***
- I saw the patient with the resident, discussed the case and agree with findings and plan.
    - I agree with the resident's note with the exception of: ***

Imaging and Diagnostics:
I personally reviewed the *** image(s) and agree with the resident's findings
I personally reviewed the *** and agree with the resident's interpretation with no exceptions.
I personally reviewed the *** agree with the resident's interpretation with the exception of: ***

Minor procedures: I was present and supervised the entire procedure.
Major Procedures: I was present for the key portions of the procedure.
Key portions included: ***

Smart Phrase name: NPPreview
I read the non-physician provider's note and agree with the findings and plan.

Make Me the Author

This Epic functionality is similar to Shared Notes but is optimized for the ambulatory setting. It is available to all clinical users with note writing access. Appropriate use should be constrained by existing local standard workflows or policy and procedures.

The Make Me the Author (MMTA) button appears when editing another user's unsigned note. Workflows utilizing MMTA in the ambulatory setting will typical involve the support staff entering data to begin a progress note for an office visit. After the support staff completes their normal workflow, the provider comes in and continues the exam with some clinical data already entered. The provider can then make themselves the author of that note with the MMTA button, finish up the documentation, and take full responsibility for it upon signing.

Reconciling External Medical Records

There are a number of ways that outside information gets into Epic:

- Care Everywhere
- CCD (health exchange)
- Patient reported information via MyChart

The following tables reflect the ability of each clinical user to reconcile external medical records into the Houston Methodist Epic record.

Can User Perform this Task?	MD	NP & PA	Fellow & Resident	RN	MA	Research Coord*	Abstractor
View & add Immunizations from outside sources	View & Add	View & Add	View & Add	View & Add	View & Add	View & Add	View & Add
Discard Immunizations from outside sources	Yes	Yes	Yes	Yes	Yes	Yes	No
View & add allergies from outside sources	View & Add	View & Add	View & Add	View & Add	View & Add	View & Add	View & Add
Discard allergies from outside sources	Yes	Yes	Yes	Yes	Yes	Yes	No
View & add medications from outside sources	View & Add	View & Add	View & Add	View & Add	View & Add	View & Add	View & Add
Discard medications from outside sources	Yes	Yes	Yes	Yes			
View & add problem list information from outside sources	View & Add	View & Add	View & Add		View Only		
Discard problem list information from outside sources	Yes	Yes	Yes				

Problem List

The Problem List is a list of acute and/or chronic **ACTIVE** medical conditions. It is an organizational tool to help clinicians easily identify and manage individual medical problems and their related complications.

Why it is important:

- Global communication tool
- Essential for continuity of care
- Improves efficiency of practice
- Necessary for decision support to function correctly in Epic. (Examples of decision support: Best Practice Alerts, Health Maintenance, order set suggestions, Registries)
- Facilitates accurate inpatient severity of illness scores and ambulatory Risk Adjustment Factor scores
- Requirement for ambulatory and hospital Meaningful Use and inpatient Core Measures
- Supports research, data reports, and quality measurement programs
- Will be viewed by patients through their MyChart account

Expectations:

All providers have responsibility for updating and maintaining the problem list. Below is a table outlining the problem list tasks and the providers who have ultimate responsibility for completing the tasks.

Problem List Responsibilities

Task	Responsible Provider
Review the Problem List at each encounter or admission and reconcile	All Providers
Add new problems to the problem list	Diagnosing Provider OR Provider Reviewing Outside Documentation
Update and refine problems as more specific diagnoses are made	Diagnosing Provider
Resolve inactive problems without future implications	All Providers
Move inactive chronic or recurrent problems to medical history	All Providers
"Delete" erroneous problems	All Providers
Uncheck the "Share w/pt box" in the rare instance where the patient should not see a sensitive problem.	All Providers
Avoid creating duplicate problems	All Providers
Delete duplicate problems.	All Providers
Mark all problems addressed during hospitalization as "Hospital Problems".	Inpatient Providers
Resolve Surgical Problems when they are corrected	Surgical Providers

Problem List Content

Appropriate Content for Problem List	Exclude from Problem List
Chronic medical problems requiring continued treatment, screening or monitoring *Type 2 diabetes, essential hypertension, chronic kidney disease, developmental delay*	**Inactive or historical medical problems and completed surgeries** *Appendectomy, CABG, TURP, ankle fracture, knee replacement*
Recurring acute medical problems requiring evaluation or treatment *Recurrent UTIs, recurrent shoulder dislocation*	**Minor, self-limited illnesses or complaints**. *URI, rash, skin tag, ankle sprain*
Problems requiring the prescription of scheduled or PRN medications chronically *Anxiety, migraine, sciatica, SBE prophylaxis candidate*	**Non-problems** *Reminders, notes, insignificant social history*
Problems requiring laboratory testing for monitoring *Thyroid disease, atrial fibrillation*	**Family history of limited or no significant health risk to the patient** *Family history of appendectomy or alopecia*
Acute symptoms while under active evaluation for diagnosis *Abdominal pain, low back pain, chest pain, sepsis*	**Screening procedures or health maintenance documentation** *Mammogram, vaccinations, colonoscopy, EKG, stress tests, bone density*
Active or relapsing chemical dependency or abuse *Tobacco abuse, narcotic dependence*	**Symptoms, when a diagnosis exists** *Cough when asthma is present*
Family history of disease that conveys a significant health risk upon the patient *Family history of BRCA gene positive, family history of Huntington's Disease*	**General diagnosis, when a specific one exists** *Sciatica when herniated lumbar disc is present*
Chronic mental health disease *Depression, schizophrenia, PTSD*	
Positive screening tests that impact continuing care or disease risk ***Abnormal PAP smear, positive PPD***	
Risk Adjustment Factor-related problems *CKD, COPD, old MI, recurrent depression*	

Additional expectations for inpatient physicians:

- ✓ Mark all problems addressed during hospitalization as "Hospital Problems."
- ✓ Avoid creating a duplicate diagnosis. If a patient is admitted for an exacerbation of an existing condition already noted on the problem list, refine or modify the diagnosis as the condition evolves. (e.g. COPD →acute exacerbation of COPD→COPD)
- ✓ Reconcile all problems on the problem list at the time of admission and discharge.

- ✓ Resolve surgical problems when they are corrected. When post-operative care is complete, the surgical problem should be resolved from the Problem List. (The surgical procedure performed should reside in PSH.)

Appropriate Content for Problem List During Hospitalization
Admitting diagnoses *Sepsis, pneumonia, UTI*
Chronic diagnoses which are being addressed during the hospitalization *Diabetes, asthma, chronic kidney disease*
Newly diagnosed medical problems which will require treatment, screening, monitoring or supplies *Diabetes, obstructive sleep apnea, COPD, hypoxemia, PEG insertion*
Diagnoses which are being mentioned or discussed in the progress notes *Hypokalemia, malnutrition, non-compliance*

Items to Modify or Resolve During Hospitalization
Surgical problems which have resolved following surgical correction *Cholecystitis, appendicitis*
Transient medical conditions *Dehydration, hypokalemia, pregnancy*

Medical History

The medical history is a comprehensive list of all significant **ACTIVE and HISTORICAL** problems. All clinical providers (physicians, PAs, NPs, RNs, MAs, case managers, social workers, and research coordinators) are responsible for capturing the patient's medical history in the EHR.

Why it is important:

- Essential for continuity of care
- Improves efficiency of practice
- Necessary for decision support to function correctly in Epic. (e.g. Best Practice Alerts)
- Supports research, data reports, and quality measurement programs
- Will be viewed by patients through their MyChart account

Expectations:

- Providers should at minimum review and update the medical history as follows:

Provider Type	Minimum Frequency of Review
Ambulatory Providers	Once a year at the time of an annual visit or examination
ED Providers	Each encounter
Inpatient Providers	At the time of admission and discharge

- Providers should mark the section as reviewed (recommended)
- Providers should synchronize active problems on the Problem List with Medical History by clicking "File to Hx" (within Problem List) or "Add to Problem List" (within Medical History)
- Providers should follow the following guidelines when documenting medical history:

Items to Include	Items to Exclude
Significant prior medical conditions *Pneumonia, diverticulitis, PE, nephrolithiasis*	**Self-limited or temporary problems** *Contact dermatitis, conjunctivitis, hypokalemia*
Chronic conditions which have resolved *Obesity, HTN, OSA, dyslipidemia*	**Symptoms** *Knee pain, shortness of breath, chest pain*
Problems which may recur in the future *Asthma, HTN, depression, febrile seizure*	**Inconsequential Problems** Tinea pedis, sunburn, ganglion cyst
Problems which required an extended period of care in the past *DVT, hip fracture, Guillian-Barre, ARDS*	**Remote historical problems without continued importance** *Achilles tendonitis, finger fracture, appendicitis*

Medications

The medication list is a common list of **active** medications for a given patient.

Expectations:

When documenting in EPIC:

- The Medication List should include all active acute and chronic medications, prn medications available for current use, scheduled infusions or injectables, hormones, vitamins, supplements, etc.
- Providers will "Mark as reviewed" after reviewing the medication list to comply with Meaningful Use.
- Providers will use discrete fields when possible to optimize e-prescribing ability.
- Providers should associate a diagnosis with a medication. While this is not required it is highly recommended as it clarifies the intended use of the medication to all providers and the patient.
- Providers will prescribe all medications from within the EPIC EHR.

Medication Reconciliation

In order to ensure patient safety and meet meaningful use requirements, medication reconciliation must occur as follows:

Required Medication Reconciliation	Responsible Party
Each Outpatient Encounter	Clinical Staff, Verified by Provider
Each Change of Medication	Provider
Admission	Clinical Staff, Verified by Provider
Discharge	Clinical Staff, Verified by Provider
ED Visit	Clinical Staff, Verified by Provider
Transfer	Clinical Staff, Verified by Provider

Allergies

The allergy list should contain a list of a patient's allergies to medications, foods, and vaccines. Maintaining an accurate allergy list is important for patient safety and the Allergy List drives decision support alerts that support patient safety.

Expectations:

- Allergies should be reviewed are updated at every visit.
- Whenever possible enter a specific drug name and document the reaction and severity using discrete data
- Responsibility for documenting in the allergy section of the EHR is as follows:

Allergy List Tasks	Responsible Party
Update Allergy List	Clinical Staff or Provider
Verify Allergies and Document Reaction	Provider
Delete Allergy	Provider or Pharmacist

Health Maintenance

The health maintenance activity helps drive preventative medicine for the patient. This includes physical exams, mammograms, colonoscopy, etc.

Expectations:

All providers and clinical staff take an active role in documenting completion of preventive services.

Timely Documentation

Timely documentation is required to improve quality of patient care and patient safety by facilitating communication between providers across the continuum and also to facilitate timely revenue capture.

Expectations:

- All encounter, progress notes, ED notes, Op notes, procedure notes, consult notes, etc. should be completed at the time of encounter or event allowing documentation to be immediately available to other providers for patient care.
- Ambulatory Encounters must be closed within 24 hours.
- Inpatient documentation must be completed by 12 hours post-discharge.

In Basket

In Basket is a secure, closed messaging system that allows users to send and receive messages about patient care and billing needs within Epic. In Basket is similar to email, except that you can directly link messages to patients' accounts, charts, lab results, and orders.

Expectations:

Key Ambulatory In Basket Folders

In Basket Folder	Definition	Recommended Time for Completion
Results	Contains lab results, imaging, etc.	24 hours
Results (Critical or time sensitive)	Contains lab results, imaging, etc.	Same day
Patient Calls	Telephone encounters that require clinician input.	Same day
Patient Calls (Urgent)	As above.	4 Hours
Pt Advice Request (MyChart)	Patient requests for medical advice via MyChart.	Same day
Rx Request	Patient/Pharmacy/Surescripts requesting medication refill that requires provider approval.	Same day
My Open Charts	System-generated list of patient visit encounters that have not been closed for over 24 hours. These require the provider to complete the required elements and close the encounter to drop charges for these visits.	24 hours
Cosign Orders	Orders requiring co-signature.	Same day
Cosign-Charts	Notes requiring co-signature.	24 hours
CC'd Charts	Messages that include patient charts that another provider has carbon-copied to you for your review.	24 hours (Same day if urgent)

- Out-of-office guidelines: Each practice will determine In Basket coverage when providers are unable to access their In Basket for a number of hours. The In Basket can be assigned to covering providers or to nurses.

Key Inpatient In Basket Folders

In Basket Folder	Definition	Recommended Time for Completion
Hospital Chart Completion	A centralized folder from which a provider can complete any outstanding documentation on a chart or sign off on interns requiring the signature.	48 hours (Or 2 business days)
Transcriptions	Folder from which providers can review, edit, reject and sign Partial Dictation Notes.	2 days (Same day if urgent)
Overdue Results	Notifies you when Inpatient Orders have not been Resulted after a defined amount of time. Based on this information, providers can cancel the order.	24 hours
Cosign Notes	Providers will see notes that only they need to cosign.	24 hours
Verbal Orders	Review and Co-signing Verbal Orders	24 hours
My Incomplete Notes	Providers can review any notes they have not completed yet.	48 hours
Coding Queries	Queries Sent for Providers	TBD

Charting Tools

The following charting tools available for documentation:

Note Type	Smart Text/Free Text	Notewriter	(Unstructured) Entire Note Dictation	(Structured) Partial Note Dictation	Voice Recognition
Ambulatory Progress Notes					
Patient Specific Values **	Yes	Yes	***all elements will pull over form EMR***		
HPI	Yes	Yes	No	Yes	Yes
Assessment	Yes	Yes	No	Yes	Yes
Plan	Yes	Yes	No	Yes	Yes
Office Procedures	Yes	Yes	No	Yes	Yes
Subspecialty Group Notes	Yes	Yes	No	Yes	Yes
Group Notes	Yes	Yes	No	Yes	Yes
Inpatient Notes					
IP H&P	Yes	Yes	Exception*	Yes	Yes
Surgical H&P	Yes	Yes	Exception*	Yes	Yes
Progress Notes	Yes	Yes	No	Yes	Yes
D/C Summary	Yes	Yes	No	Yes	Yes
Letters	Yes	Yes	No	Yes	Yes
Procedure Notes	Yes	Yes	No	Yes	Yes
Bedside Procedure Notes	Yes	Yes	No	Yes	Yes
Consults	Yes	Yes	Exception*	Yes	Yes
Brief Op Note	Yes	N/A	No	Yes	Yes
Operative Note	Yes	N/A	Exception*	Yes	Yes
ED Provider Note	Yes	Yes	No	Yes	Yes
ED Note	Yes	N/A	No	Yes	Yes
Psych Note	Yes	N/A	No	Yes	Yes
Code Documentation	Yes	N/A	No	Yes	Yes
Downtime Event Note	Yes	N/A	Exception*	Yes	Yes
Nursing Notes	Yes	N/A	No	Yes	Yes
Plan of Care	Yes	N/A	No	Yes	Yes
Treatment Plan	Yes	N/A	No	Yes	Yes
Significant Event	Yes	N/A	Exception*	Yes	Yes

*Exception by policy
**This includes vitals, allergies, medications, social and family history, as well as surgical history

Final Comments

Optimal use of the EHR will be fostered by adhering to the principles and practices outlined here. The burden of chart maintenance should fall on no single provider, but is a shared responsibility of all providers over time. Consistent practices and a shared effort at chart maintenance will increase both provider and patient satisfaction with the EHR at Houston Methodist and will allow the EHR to be used to its fullest potential.

Appendix I – Note Framework

Note Type	Required Elements
H&P, Consult, Admission Note	• Limited patient demographic descriptors (Name, age, sex) • Chief complaint (reason for visit) • HPI (History of Present Illness or Subjective) • PMH, PSH, SMH, FMH, Meds, Allergies • ROS • PE including vital signs • Labs, Rad, Diagnostics • Differential Diagnosis • Assessment (which may include narrative and ICD codes) • Plan (including narrative description and all orders)
Operative Note	• Limited patient demographic descriptors (Name, age, sex,) • Date & Location of Procedure • Name of Surgeon • Assistant (s) • Preoperative Diagnosis • Postoperative Diagnosis • Operation Name • Anesthesia • Complications • Specimens Removed • Grafts/Implants • Synopsis
Brief Post-Operative Note	• Limited patient demographic descriptors (Name, age, sex) • Date & Location of Procedure • Name of Surgeon • Assistant (s) • Indication for Procedure • Preoperative & Postoperative Diagnosis • Procedure Name • Anesthesia • Complications • Estimated Blood Loss • Specimens Removed • Blood Products Administered • Grafts/Implants • Synopsis of Findings

Note Type	Required Elements
Patient Procedure Note	• Limited patient demographic descriptors (Name, Medical Record) • Date & Location of Procedure • Name of Provider • Assistant (s) • Procedure • Anesthesia • Estimated Blood Loss • Complications • Disposition • Synopsis/Description of the Procedure Synopsis of Findings
Discharge Summary	• Limited patient demographic descriptors (Name, Medical Record) • Admission & Discharge Dates • Provisional Diagnosis or Reason for Admission • Final Principal Diagnosis • Secondary Diagnosis • Complications • Co-morbid Conditions • Operations & Procedures Performed • History & Essential Physical Findings • Hospital Course & Treatment Rendered • Condition on Discharge • Final Disposition • Pertinent patient instruction: • Meds • Diet • Follow up Care • Physical Activity **A final progress note may be substituted for a discharge summary for the following: • Uncomplicated hospitalization with a length of stay not exceeding 48 hours • Uncomplicated delivery • Normal Newborn

Note Type	Required Elements
Death Summary	• A discharge summary entitled "Death Summary" will still be required for an inpatient death, regardless of the length of stay • Code Blue Notes are not acceptable as a discharge/death summary
Ambulatory SOAP Note	• Limited patient demographic descriptors (Name, age, sex) • Chief complaint (reason for visit) • HPI (History of Present Illness or Subjective) • PMH, PSH, SMH, FMH, Meds, Allergies (if required • ROS (if required for level of complexity) • PE including vital signs • Labs, Rad, Diagnostics • Differential Diagnosis • Assessment (which may include narrative and ICD codes) • Plan (including narrative description and all orders)
Ambulatory Procedure Note	• Limited patient demographic descriptors (Name, Medical Record) • Date & Location of Procedure • Name of Provider • Procedure • Consent • Anesthesia • Complications • Synopsis/Description of the Procedure Synopsis of Findings

Appendix II – Glossary of Key Epic Terms

After Visit Summary - Report summarizing such things as orders, diagnoses, and notes for an encounter that you can print and send home with the patient. Sometimes abbreviated AVS.

Care Everywhere - An application that provides access at the point of care to the patient's medical records from other organizations.

InBasket - Electronic messaging system used within Epic applications. Does not work outside Epic.

- **Attached InBasket** - Another user's In Basket that has been linked to yours, either manually or automatically, to allow you to cover work for her/him.
- **InBasket Message** - A message that is sent to inform a user of something in the system. In Basket messages can be manually sent by other users or automatically generated by the system.
- **InBasket Pool** - Used to send a shared message to a group of recipients. When you send a message to a pool, everyone in that pool gets the message, but after one person marks it as "Done" it disappears from the other users' In Baskets. Used if any member of the group can perform the requested action. Common examples include transcription pools and phlebotomist pools.

Encounter - A clinical contact with a patient. For example, an office visit, a telephone call, or an "orders only" visit. If more than one evaluation or procedure takes place at that visit, it is still usually considered one encounter.

History Activity - Activity where you can view and document a patient's medical, surgical, family, and socioeconomic history. You might also be able to access this information from the History navigator section.

Letter template - The basis of a letter in Epic. Composed of blocks of text, SmartLinks, and SmartLists. One possible use for a letter template is to create letters to send to referring providers from specialists regarding consult visits.

Media Manager - Activity in Hyperspace where you can manage the media files in a patient's chart. This activity includes scanning functionality. You can enter new files into the patient record as well as view, edit, move, or delete all existing files.

MyChart - Epic application that allows patients to view their medical records and interact with their physicians over the Internet.

Orders - EpicCare allows providers to directly enter orders for diagnostic imaging, labs, medications, DME, and referrals. Results return electronically (for diagnostic imaging and labs) to a provider's In Basket. Medications ordered in EpicCare can be automatically faxed or printed on tamper-proof paper.

Patient Lists - Activity where you can assemble and view lists of patients and view reports for each patient, e.g. a list of patients with specific condition such as diabetes. You can also open a patient's hospital chart from here by double-clicking that patient.

Preference List - A set of frequently used orders. Orders can be added to clinic-specific preference lists by members of your clinic, and you can also maintain your own personal preference list to include orders you have pre-configured based on your preferences.

Report - A summary of information related to a given topic, such as an encounter or an order, that can be printed, viewed on screen, faxed, or sent using e-mail or In Basket. An After Visit Summary is an example of a report. LRP Reports are made up of one or more print groups.

SmartTools - a collection of Epic tools that improve documentation speed and efficiency

- **SmartPhrase** - A SmartTool that allows you to type a few characters that automatically expand into a longer phrase or block of text. For example, .pt becomes patient.
- **SmartList** - A SmartTool that allows you to choose from a list of pre-configured choices in a SmartText or SmartPhrase. These can be single- or multiple-response lists.
- **SmartText** - A text template for charting that can include text, SmartPhrases, SmartLists, and SmartLinks. Frequently used in progress notes.
- **SmartSet** - A documentation template. A group of orders and other elements, such as notes, chief complaints, and levels of service, that are commonly used together to document a specific type of visit.
- **SmartForm** - A customizable form in Hyperspace used for gathering clinical and other patient data.

Visit Navigator - A charting template that contains sections where you can document information related to many of the standard components of an office visit.