DESCHUTES RIM Health Clinic	Policy Description EMR (Electronic Medical Record) Policy & Protocols	DEPARTMENT Operations	POLICY NUMBER: OP-07
ORIGINAL DATE: 03/15/2021	RESPONSIBLE PARTY: Clinic Manager Medical Director		REVISED DATE:
APPROVAL DATE: 03/17/2021	DATE REVIEWED: 03/17/2021		APPROVED BY: BOARD OF DIRECTORS
RESOLUTION NO:		BOARD CHAIR:	Dennis Beechler

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EMR (Electronic Medical Record) Policy and Protocols White River Health District dba Deschutes Rim Health Clinic:

In compliance with relevant State and Federal laws, Ethical Standards set by CMS (Center Medicare and Medicaid) and Licensing requirements for Medical and Dental providers; White River Health District dba Deschutes Rim Health Clinic will engage in the following Policy and Protocols to assure segregation of duties, all Ethical standards for Medicare Fraud and Abuse and reportable noncompliance of Licensing requirements are followed to produce the highest degree of accuracy in the EMR (Electronic Medical Record)

PURPOSE: It is the goal of this policy to provide clear and consistent guidelines for all staff working at the Deschutes Rim Health Clinic to understand the requirements of documentation for every patient request and/or visit at the clinic. This will also define who is responsible for each component of a patient visit and to identify a process for resolution should there be an unacceptable occurrence.

DEFINITIONS:

Completion: The process of *completing an entry* in the health record by which documentation related to the visit is completed by the provider. The signature is applied, and the entry is considered complete. An entry is complete when the DONE button is clicked.

Locked: The process by which health record entry is deemed complete. Once "locked" any changes to the entry must be made through an amendment. Records will be electronically "signed" by the provider/staff when closed. Once locked the billing processes can be applied.

Required Entry: A completed medical record shall include the entry of the following (at minimum): chief complaint, history of present illness (HPI), current meds, past medical history, allergies, vital signs, exam, assessment, treatment consistent with chief complaint, visit code and follow/up.

POLICY:

Medical records must be locked within 72 hours of client visit. Failure to complete records within specified timeframes may result in disciplinary action as defined in this policy.

Prompt documentation of a medical encounter ensures:

- the provider or nurse remembers the encounter accurately.
- up-to-date advice by the health care team, especially if the patient, pharmacist, or other health care professional calls for clarification of a visit decision
- timely billing

PROCEDURE:

Timely completion:

All health records will be complete and locked within 72 hours by individuals responsible for that encounter and/or who are permitted to document in the medical record.

1. For every patient visit with provider, the problem list, medication list, medication allergy list, and any future appointments must be documented and/or updated before the patient checks out for client to receive his/her clinical visit summary. This is achieved by:
   - Clinical visit summary is printed with each visit.
   - Client is enrolled and information is available through Client Portal.
2. If the provider is going on vacation or will not be in the office for an extended period, all records must be signed before leaving on that time off.
3. Telephone encounters will be utilized for all communication when communicating to a patient for any medical issue or concern. These should be completed by the end of the same business day but no later than 48 hours.
   - More than one staff person will be able to add to the note as the issue evolves over time.
   - If the patient call is not resolved within 48 hours due to the inability to reach the patient (patient will not return calls, bad phone number, etc.) this information should be documented in the note, then closed and signed. A new note can be started if the patient calls back after that time.
4. For abnormal results, per provider's orders, a clinical staff member will attempt to contact the patient/parent/guardian.
   - If telephone contact is unsuccessful after at least three attempts, or disconnected phone number, then a written letter will be sent in accordance with the Test Tracking Procedure.
   - This information must be documented in the note.
   - Non-urgent laboratory items need to be reviewed and managed within 24 hours of the results being received.
   - Critical laboratory results are reported by the laboratory to the provider.

- The lab company will call the individual provider's clinic during normal office hours for critical lab results.
- After normal hours, the lab company will reach the provider through contact information on record for after hour calls.
- Providers on vacation: Other providers or nurses will be assigned to vacationing provider jellybeans to view for critical labs or diagnostic results while the provider is away.

5. If a patient is seen for a nurse only visit (example: injection, immunization, dressing change, etc.), it is documented in the progress note and locked.
   - Verbal telephone orders are countersigned by the prescriber within 24 hours.
   - Immunizations are documented in a progress note and the immunization record is updated automatically from this documentation. Historical immunizations can be added during a regular visit through the immunization link or through a telephone encounter and by directly updating the immunization record.

6. **Medical record Entries:**

   - Entries in the medical record shall be made only by members of the professional staff, nursing staff, Deschutes Rim Health Clinic health professionals and White River Health District employees as authorized by White River Health District and professional staff rules.
   - Medical record entries shall be made only by personnel directly involved in treatment or observation of the patient and recorded at or about the time of treatment or observation.
   - Health care personnel currently licensed, registered, or certified may accept and record verbal orders related to their licensure or scope of practice. This includes orders for Laboratory and other ancillary services.
   - The following health care personnel currently licensed, registered, or certified in the State of Oregon shall be authorized to accept verbal or telephone orders for medications within their scope of practice.

7. **Recording Entries in the Medical Records**:
   i. All entries in the medical record automatically identify the date and time of the entry. The date and time will identify when the entry is made, regardless of whether it relates to prior events.
   ii. All entries in the medical record shall be factual; irrelevant information and humor should be avoided in recording entries. If opinions are entered into the medical record, they shall be clearly identified as such by leading the notation with "in my opinion...".

8. Errors and Corrections

i. Errors in the medical record shall be corrected by creating an addendum and noting the error.

ii. All corrections shall be time stamped with staff/provider name and date.

iii. Signatures – Authentication All documentation in the Electronic Health Record (EHR) progress notes or telephone encounters will be electronically signed by the White River Health District employee responsible for locking the note when the encounter is complete.

iv. No White River Health District employee shall authenticate an entry for another person. The parts of the medical record that are the responsibility of the medical practitioner are to be authenticated by him/her.

v. It is also acceptable for a covering physician to sign the verbal order of the ordering physician. The signature indicates that the covering physician assumes responsibility for his/her colleague's order as being complete, accurate and final. All orders, including verbal orders, must be dated, timed, and authenticated promptly by the prescribing practitioner or another practitioner responsible for the care of the patient, even if the order did not originate with him/her.

vi. The Covering Physician is a physician of the same specialty as the attending or consulting physician who assumes responsibility for the care of the patient within a specific time frame.

9. Monitoring

- Completion of charts will be monitored every two weeks by appropriate designee, Clinic manager.
- Report of unlocked records (delinquencies) will be communicated via email to providers and Medical Director.
- A monthly compliance report will be presented to the Medical Director and QA representative, and any non-compliance will be presented to the Board with a workplan on how to resolve.

10. Incomplete Medical Records and Delinquencies

- The medical record shall be completed within 72 hours after the patient visit.
- A provider should only complete a medical record on a patient that is familiar to him to retire a record of another staff member.
- The Medical Director or designee may retire the medical record as "incomplete" only if the physician is deceased, has moved from the area, has resigned from the medical staff, or is on an extended leave of absence. In this situation the following statement will be added to the record:

  "incomplete" Due to the departure/death/or permanent incapacitation of the health care provider the_____report is unavailable, and this record is

being filed incomplete by order of the Medical Director_____"
Sign/Date_____

Delinquent Medical Records are managed in accordance with the Employee Handbook Policy for Disciplinary Action. Compliance to the policy will be considered in evaluations and/or privileging processes including professional peer review. Providers will not be granted annual leave or CME days if records are not completed. Any disciplinary action for this offense is a permanent part of the employee record and after 3 disciplinary filings will be terminated and be reported to the state licensing board.

Scheduling/Office Assistant Requirements/Non-Clinical Staff:

1. It is our practice to schedule all appointments into the EMR (Electronic Medical Record) program at the time an appointment is made. It is also our practice to create telephone encounters when communication for any medical need, referral or request is made from the patient for the staff at the clinic. This will create a tracking document in the patient separate identifiable record (EMR)
2. Upon Arrival for appointment, registration paperwork is completed, updated, verified, and if monies due will be asked for prior to services. The Office assistant will then move patient into a checked in status in the EMR (Electronic Medical Record).
3. To handle phone calls from a patient that are asking for a return call prior to scheduling an appointment for a medical issues or questions, a telephone encounter is created and assigned to the personnel who will complete the task and document outcomes.
4. Once a patient has completed their visit Office Assistant personnel will check out the patient in the EMR (Electronic Medical Record). This will then close out the Scheduling/Office Assistant responsibility in the Encounter process.

All other Deschutes Rim Health Clinic personnel will adhere to the above Policy and Protocol and will be part of the Clinical staff team entering data directly into patient chart for information gathering to assist the provider with his/her assessment.

This policy adheres to requirements for Meaningful Use and Medicare Fraud and Abuse requirements.

Passed by a majority of the Board of Directors of White River Health District, with a quorum in attendance the 15th Day of March, 2021.

White River Health District dba Deschutes Rim Health Clinic

Wasco County, Oregon

By _____

Dennis Beechler, Chairman of the Board

Attest:

By _____

Suzanne Knapp, Secretary of the Board