Use of Health Information Technology to Advance Patient Care

Policies & Procedures

American College of Physicians
Leading Internal Medicine, Improving Lives

Policy:

Our practice uses health information technology to best of our ability to advance patient care – including the health of individuals as well the population we serve.

Purpose:

In order for health information technology to support improving health of our patients, all practice staff must be familiar with appropriate use of the technology. "Use" includes capturing information in standardized ways as instructed; maintaining clinical records as complete as possible; adhering to all security and privacy requirements; updating information when appropriate; leveraging reports to advance the care of individuals and the population.

Procedure:

General Issues
1. All new staff undergoes extensive training on the then current health information technology being used in the practice.
2. Existing staff undergo periodic review and re-training on health information technology in use.
3. On an annual basis, all staff must demonstrate adequate knowledge of privacy and security regulations (i.e., HIPAA) and the appropriate processes to protect individually identifiable health information (both electronic and paper-based records).

Use of Electronic Health Records & Practice Management System
1. Practice staff collect the following <u>demographic</u> information in structured data fields for the office records on <u>ALL</u> patients:
    a. Date of birth
    b. Gender
    c. Race
    d. Ethnicity
    e. Language
    f. Preferred language
    g. Telephone number
    h. Address
    i. Email address
    j. Primary caregiver (if not self)
    k. Health insurance information
2. Practice staff collect the following clinical information (in structured data fields if they exist) for the office records and maintain this information up-to-date on <u>ALL</u> patients:
    a. Vital signs including:
        i. Height
        ii. Weight
        iii. Head circumference, length, weight (for children ≤ 2 years old)
        iv. Body mass index
        v. Blood pressure
        vi. Pulse
        vii. Tobacco use
    b. Problem list with current/active diagnoses/conditions

      c. Medications (prescription and over-the-counter)
      d. Allergies/adverse reactions
      e. Presence/absence of advance directives
           i. Also capture location of where most recent/updated advance directive can be found in an emergency
3. Practice staff use health information technology to:
      a. Identify medication interactions:
           i. Drug-drug
           ii. Drug-allergy
           iii. Drug-laboratory test (i.e., renal insufficiency or abnormal liver-associated enzymes)
      b. Generate reports that help manage patients and populations such as:
           i. Patients with specific diagnoses/conditions who have missed scheduled follow-up;
           ii. Patients due for preventive care visits or interventions (i.e., cancer screening, vaccination);
           iii. Patients due for laboratory tests or other procedures on the basis of previously abnormal results or on the basis of their clinical condition and practice guidelines;
           iv. Patients on specific medications that require periodic laboratory tests or monitoring – or in the case of a recalled medication, generate a list of patients who need to be contacted about the recall
      c. Generate electronic prescriptions including new prescriptions and renewals
      d. Order laboratory and imaging procedures
      e. Retrieve laboratory, imaging and other test results
      f. Track ordered tests/procedures and identify overdue results in order to retrieve them
      g. Track referral/consultation requests to ensure the results are received
      h. Generate reports on quality indicators
      i. Generate reports on practice:
           i. Efficiency
           ii. Billing
           iii. Coding
      j. Report quality indicators to external entities such as the Centers for Medicare & Medicaid Services