Health Information Management

- Hours of Operation
- Dictation
  - Timeliness
  - Requirements

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Health Information Management, also known as Medical Records, is open Monday through Friday, 8:00 am to 8:00 pm.

Records are scanned in to HPF 24 hours following patient discharge and viewable in Clinician Portal. Records can be completed via the Clinician Portal and physicians need to log in weekly to monitor their incomplete record status and avoid suspension. It is the physician's responsibility to monitor their incomplete records in portal and to complete it before reaching 30 days delinquency. Notification of incomplete records by HIM is only a courtesy.

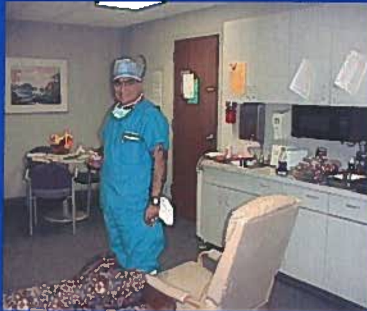
Dictation stations are located in all patient care areas throughout the hospital. We provide a 12-hour turnaround on H&Ps, Consults and Operative Reports and 24-hour turnaround on Discharge Summaries. We do bill back our transcription service for reports that are outside the contracted turnaround times. Dictations are accessible and viewable on Meditech and Clinician Portal.

The following rules and tips help to ensure accurate and compliant documentation:

1. Verbal orders must be signed, dated and timed within 24 hours by the ordering physician.
2. Dictate your H&Ps within 24 hours of admission and/or prior to surgery and operative reports prior to transfer to the next level of care.
3. Discharge Summaries and signatures are due upon discharge of the patient.
4. The use of Electronic Signature is strongly encouraged!

Health Information Management

- Notification Process
- Coding Query Process
- Lounge



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We are proud to maintain a delinquent record count at less than half the percentage allowed by JCAHO standards.

You may probably be all too familiar with the Physician Query process which is sometimes needed in order to adequately substantiate your documentation for coding purposes. When are asked to answer a query, we will make every attempt to obtain your response as soon as possible for billing purposes. Physician Queries are generated to clarify documentation for coding purposes. The diagnosis needs to be documented on the form for policy.

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Dictation Instructions

as of Feb. 16, 2010

The system will prompt you through the steps indicated below. ***You do not have to listen to the entire prompt before pressing a key.***

Dictation Controls

2	Record / Pause (toggle)
3	Rewind
8	End Report / New Report
9	Disconnect

1. **Inside Hospital dial 544-5454**
   Outside Hospital dial 544-5454
2. **Enter your User ID and press #.**
3. **Choose from the following list of PROFILES:**
   (followed by the # key)
   1- Round Rock 4- Georgetown
   2- North Austin 5- St. David's
   3- South Austin 6- Rehab
4. **Enter the work type ID and press #.**

Work Type Code	Work Type Description	Work Type Code	Work Type Description
09	Obs Short Stay H&P	35	Electrocardiogram
10	Pre-admit H&P	36	Renal Return Visit
11	H&P	37	Renal New Pt Report
12	Consultation	39	Renal Consultation
13	Progress Note	40	Renal Transplant Annual Report
14	Operative Report	41	Bone Densitometry
15	Discharge Summary	42	CT Heart Score
16	Death Summary	43	Cystometrogram
20	Letters	44	Doppler
21	ER Report	45	Echocardiogram
22	Delivery Note	46	Electroencephalogram
23	Cardiac Catheterization	47	Electrophysiology
24	Procedure Note	48	Holter Monitor
25	Endoscopy Report	50	Myocardial Perfusion Scan
26	Sports Ortho (Hancock)	51	Peripheral Vascular Report
27	Lakeway Communication Note	52	Polysomnography
28	Sports Ortho (RR)	53	Pulmonary Function Test
29	Sun City Communication Note	54	Stress Test
30	Urgent Care Clinic Report	56	Vascular Access Report
31	Code Notes	57	Tilt Table Study
32	Post Admit Evaluation		

4. **Enter the Account Number *(NOT Medical Record Number)* and press #.**
   Begin entry ***after third zero*** (note: it will be an eight digit entry)
   (If unknown, just enter 9 followed by the # key).
5. **Press *2* to begin recording at the tone.**
   Note: The "2" toggles between pause and dictate. The button on the handset of the Dictaphones performs the same function. *Please use this "pause" function when not dictating.*
6. **Press 9 to disconnect. As confirmation of dictation, you will hear a Job ID number. OR**
   Press 8 to end and begin the next patient, then re-key work type and Patient Account Number.

Unacceptable Abbreviations	Intended Meaning	Misinterpretation	Expected Action
U	Units	O, "4"	Write out entire word "Units"
IU	International units	Misread as IV (intravenous) or the number 10	Use the word "units"
Trailing Zero (i.e. 1.0 mg)	1 mg	Misread as 10	Do NOT use trailing zeros after a decimal point
Lack of a leading zero	0.1 mg	Misread as 1 or 11 mg	ALWAYS use a zero before a decimal point
MS MSO4 MgSO4	Morphine sulfate or magnesium sulfate	Confused for one another. Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" or "magnesium sulfate"
Q.D., q.d., qd Q.O.D, q.o.d, qod	"Daily" and "every other day"	Mistaken for each other. The period after Q can be mistaken for an "I" or the "O" can be mistaken for an "I"	Write "daily" and "every other day"

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Your role in good record documentation includes using acceptable abbreviations. Health care practitioners widely use abbreviations with the intent of facilitating communication and simplifying documentation. However, the use of abbreviations can result in misinterpretations and actually contribute to medication errors.

A review of the MEDMARX error reporting program from January 2000 to August 2004 found nearly 19,000 error reports from 498 facilities that cited abbreviations as a cause of error. Fortunately, only a very small percentage (0.55%) of these errors was categorized as harmful.

The "*do not use abbreviations*" identified on this slide have also been listed as high-risk by several national organizations including, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Institute for Safe Medication Practices (ISMP). The goal is to reach 100% compliance in adhering to the "*do not use*" list.

This is a very important multidisciplinary initiative that supports patient medical safety and takes a proactive approach. Your support and adherence to not using these abbreviations is strongly encouraged.

Electronic Medical Record (EMR)

- What is the Clinician Portal?
- Physician electronic access point for clinical information
  - Integrated systems
  - Simplified sign-on—one username, one password
  - hCare Access – no more tokens
  - User-friendly, intuitive interface
  - Access to complete patient list
- Resources section
  - Clinical references
  - Training modules
  - Facility-specific information
- Accessible from hospital, home, office, or while traveling

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The portal is a viewer that pulls together clinical information for patients. It provides a user-friendly, intuitive interface for physicians, making clinical data accessible from within the hospital or remotely via simplified remote access.

Clinical Portal-Enhancements

- Electronic signature and record
- Post-discharge records available electronically
- These new features are available via Horizon Patient Folder (HPF)—a new enabling technology supported by the Health Information Management Shared Services Initiative—and will be available from within the clinician portal.

- What you need to know
- Decide which type of training will work for you
  - Web-based training (WBT)
  - One-on-one sessions
  - Or a combination of training methods
- Collect all of your clinical system passwords
- Plan to attend a training session to set up your account

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The clinician portal will also provide reference resources for physicians – including training modules for using the portal and facility and division-specific information

And because it's web-based, physicians will be able to access the portal via simplified remote access.

-the records and deficiencies are viewable by the physician in clinician portal 24-48 hours from discharge under the "incomplete" tab.

-the deficiencies are broken up into three categories (MISSING TEXT, DICTATION, SIGNATURE)

-in each category, deficiencies are color-coordinated based of aging status

- INCOMPLETE (0-15 days)= BLUE

-WARNING (16-29 days)= RED

-DELINQUENT (30+)= YELLOW

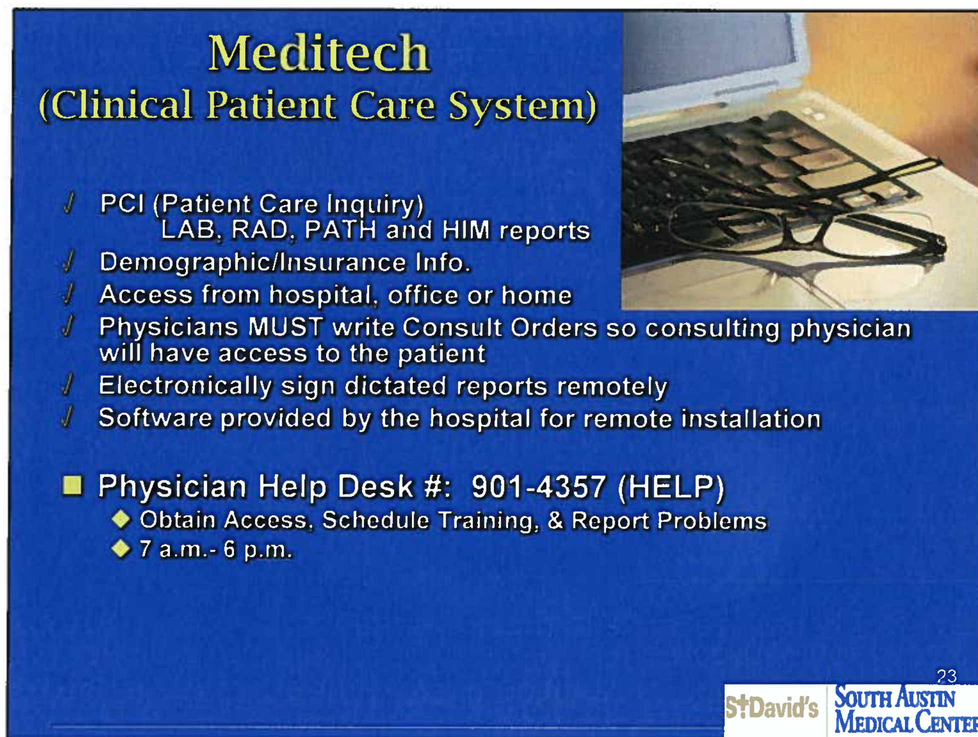
-To avoid suspension, physicians need to make sure they complete their deficiencies in warning status before reaching "delinquency" . Dictations must be dictated and signed to be considered "completed"

-As a courtesy-Notifications for suspension will be faxed to a physicians office every Wednesday with a 1 week reminder of pending suspension.

-Suspension letters will be faxed the following Wednesday

For questions about Incomplete Deficiencies- please contact Health Information Management at 816-6308

For questions about Portal or access- contact the help desk at 901-HELP or Ryder Bodoin at 816-6414



To assist you with medical record documentation, Meditech, aka CPCS, is the electronic computer system used for patient care information. This system is used market wide within the St. David's Partnership. In Meditech, we have a fully integrated Clinical, Administrative and Financial System. In addition, all the information you need regarding your patients, including an automated Rounds Report, is available to you In-house, at your office or home. Through the PCI Module of Meditech you have immediate access to Lab results, any transcribed HIM/RAD/PATH/LAB reports, as well as your patients' demographic and billing information.

If you would like to know more about our system and receive training, information about the system and forms needed to initiate the process is included in your Welcome Kit. You may also contact the Physician Help Desk.