Electronic Health Record - Required Use

Policy: All medical and allied health professional staff members must utilize the EHR as intended and to its fullest extent to meet patient care goals.

Intent: The use of an Electronic Health Records (EHR) with Computerized Provider Order Management (CPOM) offers many advantages over paper medical records including driving standardization of best practices for improved patient care, decreased variation of care providing more consistent care, the reduction of medical errors by integrating clinical decision support tools at the point of care delivery, and improved reporting mechanisms.

Competency and Training
EHR training and/or competency assessment in the use of the EHR will be required prior to a Member obtaining access to the EHR system. Privileges and authorized clinical activity is dependent upon a Member obtaining access to the EHR. Only under emergency situations and/or MEC approval will an exception be granted.

EHR Use and Etiquette
All Members will use CPOM for order entry. Verbal and telephone orders will be utilized only in urgent clinical situations. Any verbal orders and dictated reports will be authenticated electronically in a timely manner as specified by Medical Staff Bylaws or policies of the MEC. Members agree to "meaningfully use" the EHR to care for their patients. Meaningfully using the EHR currently includes the following responsibilities:

1. Members will update the active problem list within the scope of their clinical expertise at each patient encounter.
2. Members are responsible to update the active Medication List at each encounter and to perform order management (medication reconciliation) at transition of care settings.
3. Members will accurately document electronically in the EHR with exceptions as granted by the MEC. Each note will be electronically reviewed and signed in the EHR with particular attention paid to ensuring the accuracy of automated documentation tools (such as copy/paste and template text).
4. Members will review, manage and sign items in their “In Box” in the EHR in a conscientious and timely manner.
**Documentation/ Order Sets**
Utilization of the various features of the EHR, such as note templates and order sets, will support efficiencies, foster preventive services, and facilitate the use of standardized terminology. Providence-sponsored collaborative workgroups consisting of physicians and other healthcare personnel will have the delegated responsibility to create, update, revise, and remove the Order Sets that populate the EHR.

**Failure to properly use the EHR**
Failure to complete EHR training and/or demonstrate/maintain competency or disregard of the EHR Use and Etiquette principles outlined above can result in disciplinary action including, but not limited to suspension, termination, or revocation of privileges as defined in the medical staff bylaws.