HIM Provider Orientation Packet

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Contents

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Contact Information

Hours and Phone Numbers

8:00 a.m. – 4:00 p.m. – Monday through Friday (HIM Department)

No Holiday Coverage

Health Information Department	HIM	715-847-2177
Jenn Kostyn	HIM Physician Completion & Letters	715-422-9306
Shelley Stokosa	System Director of HIM, CDI, and Transcription	715-847-2617
Alex Lampe (Hospital)	System HIM Manager	715-847-2179
Krystle Grabko (Clinic)	System HIM Manager	715-847-2400
Jessica Donnell (Release of Information, Post-Acute Care)	System HIM Manager	(906) 265-0425 Ext. 11425

If there is anything, we can do to assist you, please contact us by phone or email.

Documentation Requirements

History and Physical Note Type

- o Completed within 24 hours after admission or registration.
- o Office Note within 30 days of admission. More than 30 days before current admission may NOT be used.
  - If an Office Note is used, an H&P Update is required on the day of admission and prior to a procedure requiring anesthesia services.
  - H&P Updates are done as History and Physical note type and must include that the H&P was reviewed, and patient was examined for any changes. If there are changes, they must be included in the H&P Update.

Operative/Procedure Note Type

- o Must be completed immediately after a procedure.
  - If it is not immediately completed, an Immediate Post-Operative Progress Note can be completed and the Procedure note needs to be completed within 24hrs.

Discharge Summary / Final Diagnosis Note Type

- o A full discharge summary must be done for any stay greater than 2 days, deaths, or patients with complications.
  - Completed within 30 days of discharge, day of discharge is preferred for patient continued care.
- o If a patient admission is less than 48hrs a Final Diagnosis can be completed instead of a full discharge summary.
  - It must include the final diagnosis and list of procedures from the admission.

InBasket Done/Decline

"Already Done" and "Decline" functionality is available in the Hospital Chart Completion Folder

- o If there is something assigned to you that is either already complete or something you do not feel is yours to complete, you can mark the item as either "Already Done" or "Decline". This allows you to send this back to the HIM team for review.
- o It is strongly encouraged you include information in your Done/Decline explaining the reasoning to assist HIM in understanding the background of your decision and to accurately correct the item.

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Physician Completion and Letters

- o Physicians are required to complete their medical records within 30 days of the patient's discharge.
  - o Physicians will receive YELLOW LETTER when records are over 20 days, indicating a cautionary reminder that records are getting close to the 30-day incomplete status.
  - o Physicians will receive RED LETTER indicating records are at or over the 30-day and admitting privileges may be suspended.
  - o These Red and Yellow Letters show in the InBasket under a Physician Letters InBasket Folder
  - o Physicians may receive additional requests for completion of records by email or phone if the record is needed for a request for records or if it is holding up the billing for the account.

Our goal is to ensure that the medical record is complete as soon as possible to allow for continuity of patient care. Ensuring documentation is complete allows us to make the documents available for other providers when needed. It also assists with coding and billing. If at any time there is anything we can assist with please do not hesitate to ask.

Navigation of Scanned Records

Scanned records for a patient can be found in different areas of Epic depending on what you are looking for.

Media Tab

- o This tab contains records scanned to an encounter within Epic.
- o For hospital accounts:
  - ▪ The Partial Medical Record (PMR) would be your main scan and include the main pieces of the paper chart though there is minimal information remaining in paper.
  - ▪ Other History and Physical would be the Office note being used as the H&P for the encounter
  - ▪ Anesthesia Record would be the actual Anesthesia record if the location still completes this on paper
  - ▪ Outside Records would be any records from outside facilities that were received in connection with the encounter.
- o Clinic encounters:
  - ▪ Documents that correlate with an appointment or EPIC encounter
  - ▪ Forms (FMLA, Disability, Medication Prior Auth, Med Necessity, etc)

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Off Premise Tab

- o This tab contains records from outside facilities and are labelled to include the location it was received from and a description of the records.

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Archival Tab- Call out this is where they will find records date TBD

- o This tab includes a link to the Clearsense program that houses older Aspirus records that were not created in Epic but in an alternate system. Currently Aspirus Riverview Meditech documentation is live in this tab and Divine Savior's current HER information will transition here as well.

Lab Abstraction

To help improve continuity of care for our patients and provide a more comprehensive data set to our clinical care teams, staff in the HIM department is collection and entering certain external lab results that are received in paper format. Staff are entering these results into Epic as a discrete lab value. These outside lab results will then be able to be viewed on the Lab Tab of Chart Review within Epic allowing providers/clinicians the ability to view, trend and better utilize this data to make better patient care decisions.

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CDI Query Completion

1) Access the In Basket
2) Click **Coding Query folder** to access a query sent by CDI Specialist.
3) Select Message/ query to review.
4) Click **Encounter** which will take you the summary page. Click **notes** activity to access your note and update or clarify your documentation. ** *Please note, queries must be resolved within 24-48 hours to ensure accounts are not held up for final billing.*
5) Reply to respond directly to the CDIS to ask questions or to let them know documentation has been updated. ** *This is not part of the permanent medical record. Updates need to be made within the notes to be coded.*
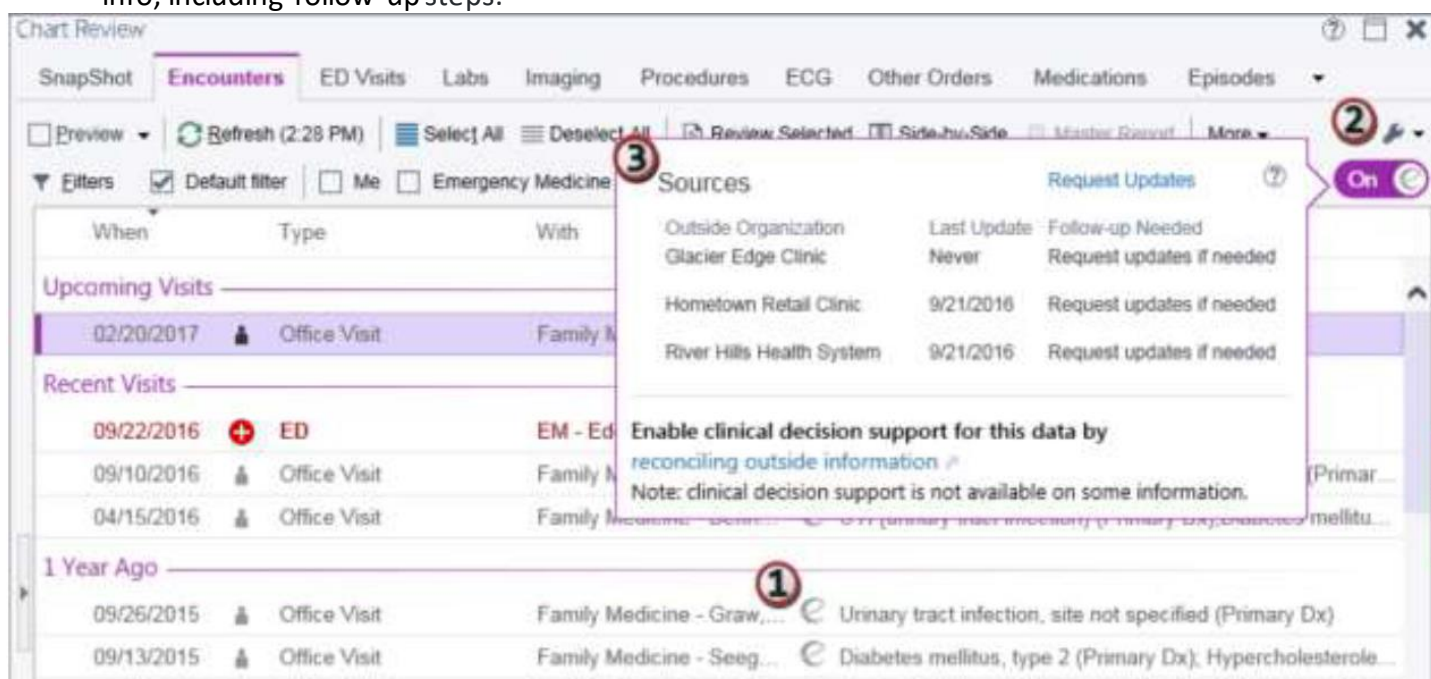6) Click **Already done** and the message will be removed from the In Basket.
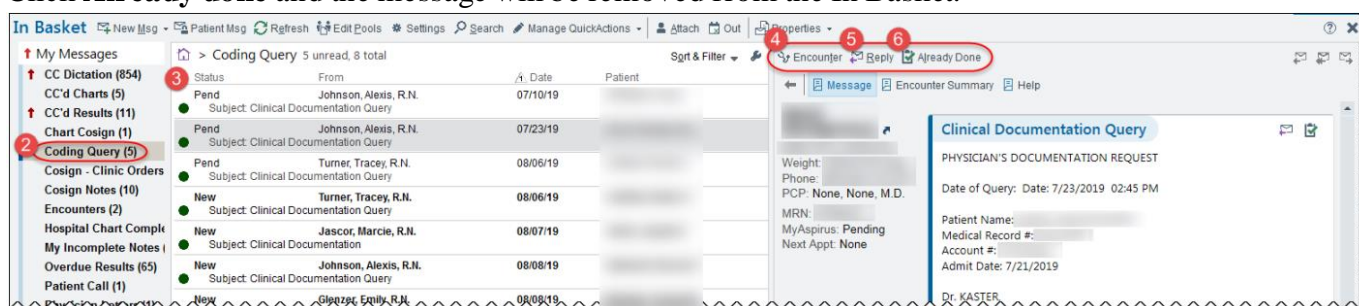
7) When you mark the Message is already done, it can be found under "completed work" section in the In Basket.
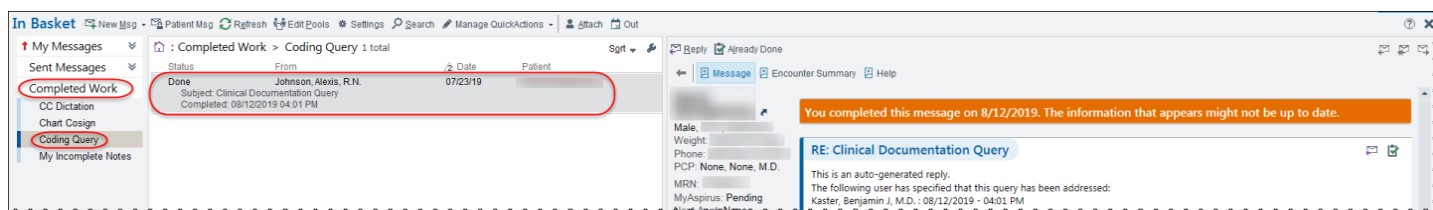
Care Everywhere

1. Review the encounters in the list. When an encounter comes from a different organization, it is indicated by the ℯ icon.

2. To see only info from your organization, click the ℯ On/Off switch at the top right of the report. If the switch is disabled, the patient doesn't have encounters from outside sources. Hover over the switch to see a list of organizations that have info for the patient and whether that info has been updated recently at your organization. Click Request updates to request the most recent info from outside sources.

3. You'll see an exclamation point on the switch if there's an issue with an outside source, like authorization needing to be collected or a communication problem. Hover over the switch for more info, including follow-up steps.

4. Select an encounter to view it in the preview pane. Click 🔄 to request the latest version of it. You might request an update, for example, if you are waiting on lab results.

5. An encounter summary can have related documents or attachments, like letters. A 📎 icon appears next to the encounter when these documents are available in the encounter summary under the Additional Documents heading.