Mission Regional Medical Center

HealtheCare

OCTOBER 2013

A Monthly Clinical Transformation Newsletter

STOP PRINTING NOVEMBER 4th

What does this mean?

We will no longer print:

- Patient Summary Reports
- Vital Signs
- Progress Notes
- H&P's
- Dictation Reports
- Lab and Radiology Results
- Consultation Reports

Dr. Angel Martinez III, EHR Champion
Clinical Informatics Medical Director

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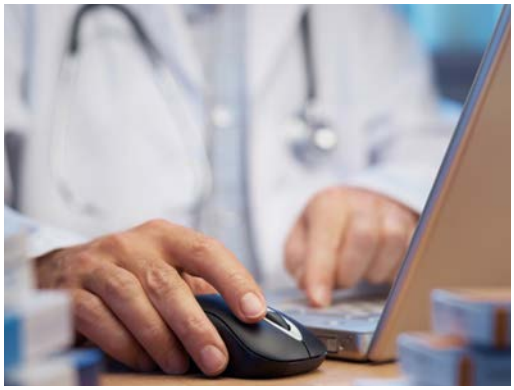
Meditech Reports



Medical Executive Committee has made physician e-signature mandatory. **EFFECTIVE NOVEMBER 4, 2013, MEDITECH REPORTS (LABS, RADIOLOGY, ETC.) WILL NO LONGER BE PRINTED.** We believe that this step is necessary to move our Medical Staff toward the upcoming transition. There will still be documentation in the patient charts that will require your signature, such as physician orders. We will make this as easy as possible for you by offering training and assistance. It won't work without you - we are looking for ways to help you so please give us your feedback.

Why Are We Doing This?

What does an Electronic Health Record mean to the Mission Regional Medical Staff?

Increased Efficiency

- Electronic Access to legible, complete, organized secure patient chart without having to be at the nurse station or waiting for paper chart access.
- Quicker Access to results and interdepartmental information
- Elimination of duplicate entry of information-one time entry will populate all areas of the electronic chart

Improved Patient Interaction

- Ability to view patient chart at the bedside while delivering care

In The Spotlight

Steven Havener, MD
Family Practice

Dr. Steven Havener took some time to speak briefly about his experience with Electronic Health Records (EHR). Here are a few of the things Dr. Havener likes about an EHR:

1) Charts are ALWAYS available, legible, organized the same way and easily searched for information. e.g. I can find a creatinine from 5 years ago and do not have to spend 5 minutes digging through a maze of papers or asking for an old chart from HIM.

2) I can standardize some of the things I always ask patients about regarding routine chronic health issues. e.g. I have standard texts that I drop into my HPI when querying patients about their diabetes, HTN or hyper cholesterol regimen. This provides a more standardized care for patients and I believe (data supports this) this leads to better patient outcomes.

3) I can swiftly and confidently build the documentation necessary to meet payor standards for reimbursement. For instance, in our office we have a standard ROS that the patient fills out and is reviewed by the provider. This often allows me to upcode to a higher level when appropriate. To hand write that ROS would be difficult.

CONGRATULATIONS TO THE MRMC EMERGENCY DEPARTMENT ON THEIR SUCCESSFUL TRANSITION WITH THE EHR!