Adventist HealthCare, Inc.
AHC Clinical Policy
Policy Name: Adventist HealthCare Electronic Health Record / Computerized Provider Order Entry Utilization Policy

Effective Date:	03/27/13	**Policy No**:	AHC CP 12.0
Cross Referenced:		**Origin**:	QM
Reviewed:		**Authority**:	SQ, PAB
Revised:	7/26/17	**Page:**	1 of 2

SCOPE
AHC facilities

PURPOSE
To define the obligations of medical staff members regarding the use of the Care Excellence Electronic Health Record (EHR) and Computerized Provider Order Entry (CPOE).

POLICY
Adventist HealthCare has implemented the Care Excellence EHR, including CPOE and electronic provider documentation at all entities. The Medical Staff, acknowledging the importance of exercising evidenced based medical practice, recognizes that members need to avail themselves of all appropriate tools and data to optimize patient outcomes. The EHR, along with CPOE and provider documentation, includes tools for standardizing best medical practice and improving the efficient delivery of health care.

Use of the EHR and CPOE, is considered to be part of the routine practice of medicine at AHC, and as such, training and mastery of the EHR and CPOE will be a condition for securing privileges at the time of appointment and re-appointment to the medical staff.

AHC has established a minimum of 80% CPOE utilization by each provider as the goal, understanding that there will be occasional exceptions. In order to reach that goal it is expected that members will enter all orders electronically with rare exception as outlined in this policy. Reports will be used to track CPOE usage and identify where utilization lags behind the 80% utilization goal.

If there are persistent actions by a member in violation of the below rules, the individual will be referred for corrective action as per the medical staff bylaws.

In order to fulfill EHR and CPOE utilization goals, the following rules shall be enforced for all medical staff members whose category of membership or whose clinical activities include ordering privileges:

1. All medical staff members will undergo training sufficient to competently use the EHR.

2. All new medical staff members must demonstrate competency in use of the EHR prior to their first patient encounter.

3. All medical staff members will complete an EHR and CPOE Utilization agreement as part of the credentialing or re-credentialing process.

4. All medical staff members are expected to comply with all policies and procedures relevant to the use of the EHR.

5. All medical staff members must use the EHR.

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6. Medical staff members may not give verbal and/or telephone orders whose sole purpose is to avoid using the EHR.

7. The nursing staff will enter telephone orders directly into the EHR. The medical staff member is required to stay on the phone while the order(s) is entered, read-back from the computer completed, and all alerts addressed.

8. Medical staff members will be expected to enter orders into the EHR unless:
   a. Medical staff member is attending an emergency
   b. Medical staff member is scrubbed in a procedure
   c. Medical staff member has no access to network or computer
   d. Exceptions to this will be allowed for individual orders or abbreviated placement orders (not full admission orders or order sets) based on the medical staff member's judgment during the hours of 12:00 AM – 6:00 AM for those providing extended call.

9. Medical staff members may not request that unit staff access patient EHR records for them as a matter of routine practice.

10. Medical staff members may not request that unit staff enter orders for them as a matter of routine practice.

11. The discharging physician (that physician responsible for performing the discharge summary) is ultimately responsible for the completion of the medication reconciliation process and the updating of the Diagnosis and Problem Lists upon discharge of the patient from the hospital.

12. Provider documentation will be completed by direct entry into the EHR or transcription. Exceptions include: Pre Op or OB H&Ps that are completed in the outpatient setting, and documentation from non-Cerner applications that are printed and scanned into Cerner. Note: The Brief Op Note must be entered directly into the EHR.

CPOE Exceptions - The order entry process will remain on paper at this time for the following circumstances:

1. Chemotherapy orders
2. Patient emergency / Code
3. Pathology orders
4. Outpatient Lab / Rad / Ambulatory Services orders
5. TPN/ NICU feeding orders
6. Apheresis
7. IgG - Pediatrics
7. Pre Op planning orders written in the office when a FIN number is not available