Gilead Medical IT Policy Statement.

The Gilead Medical & Dental Centre provides an electronic health records (EHR) system for the purposes of conducting business in support of clinical operations and patient care. All electronic records are the property of The Gilead Medical & Dental Centre and Ministry of Health. The Gilead Medical & Dental Centre and Ministry of Health reserve the right at any time to limit, restrict or deny access to its Electronic Health Record system to the extent provided by law. This document establishes guidance for creating and maintaining a quality health record in accordance with sound medical/legal practice, and to meet state and local guidelines. The use of the EHR system will be standardized and utilized in all Gilead Medical & Dental Centre clinic sites.

Application of Policy.

All Gilead Staff and Health Sector Students

Definitions.

1. **Authentication**: The process, which ensures that users are who they say, they are. The aim is to prevent unauthorized people from accessing data or using another person's identity to sign documents.

2. **Electronic Health/Medical Record "EHR/EMR":** is a medical record in digital format.

3. **Practice Management "EPM":** is the financial module that integrates the task of creating patient records, appointment scheduling, encounter maintenance, charging, billing, and collection activities.

4. **Image Control System "ICS":** this is the imaging software solution within the EMR system used to scan, index, store, and display documents.

5. **Protected Health Information "PHI":** is individually identifiable health information that is transmitted or maintained in any form or medium, including oral, written and electronic.

6. **Resident:** An individual who participates in an approved graduate medical education program. The term includes interns and fellows having the Ghana Medical Council approved certificates to practice in Ghana.

7. **Medical Student:** An individual who participates in an accredited medical educational program. A student is never considered to be an intern or a resident.

8. **Supervising Physician:** A physician (other than another resident) who involves residents in the care of his or her patients.

Procedures and Responsibilities.

1. All data contained in Gilead Medical & Dental Centre EHR related to a particular patient must be treated confidentially as required by Ghana's medical governing body.

   Responsible Party: Clinical Faculty, Staff, Students, and Residents

2. **Who May Document in the EHR:**

a) Certified Nurse Midwives

b) Dietitians

c) Dentist

d) Clinical Service Representatives

e) Licensed Vocational Nurses

f) Medical Assistants

g) Nurse Practitioners

h) Pharmacists

i) Physical Therapists

j) Physician Assistants

k) Physicians including MD's and DO's

l) Psychologists

m) Registered Nurses

n) Residents (under supervision)

o) Clinical Technicians

p) Students (under supervision)

q) Others as designated by Gilead Medical Health Policies

3. Creation of an EHR

All patients must be checked in through the Gilead Practice Management system. When the patient has been checked in through the Practice Management system, an actual patient chart is created in the EHR system.

Responsible Party: Clinic Staff

4. Content and Authentication of EHRs

a) The health care provider is responsible for reviewing and approving all patient information in the EHR.

b) All information within the EHR shall be documented accurately.

c) For each visit the following standards for medical records documentation shall be followed:

I. At least the following information, if applicable, should be entered in the patient's EHR:

a) Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results.

b) An assessment, clinical impression, or diagnosis.

c) Plan for care (including discharge plan if appropriate).

d) The date and legible identity of the observer.

II. Past and present diagnosis should be accessible to the treating and/or consulting physician.

III. The rationale for and results of diagnostic and other ancillary services should be included in the appropriate location in the EHR.

IV. The patient's progress, including response to treatment, change in diagnosis, and patient's non-compliance should be documented.

V. Relevant risk factors should be identified.

VI. The plan of care should include when appropriate:

a) Treatments and medications (prescriptions and samples) specify amount, frequency, number of refills, and dosage;

b) Referrals will be placed in the patient's record upon receipt;

c) Patient/family education; and,

d) Specific instructions for follow up.

VII. Any written consents for treatment or surgery requested from the patient/family by the physician.

VIII. Billing codes, including ICD codes reported on health insurance claim forms or billing statements should be supported by the documentation in the EMR.

IX. Providers must assure the accuracy and medical necessity of the level of Evaluation and Management ICD code recommended by the EMR before submitting the charges.

X. Any amendment, supplementation, change, or correction in an EMR shall be noted by indicating the time and date of the amendment,

supplementation, change, or correction and clearly indicating that there has been an amendment, supplementation, change, or correction.

XI. Patient records received from another physician or health care provider involved in the care or treatment of the patient will be maintained as part of the patient's medical record. This includes all pertinent diagnostic medical test reports received from providers outside of Gilead Medical Center. The provider shall review and initial the medical report. The medical report should then be abstracted into the EMR and then sent for scanning into scan software.

d) Verbal orders shall be documented in the EHR on the date of service or by the next business day.

e) Prescriptions

I. Prescribing is available through the EHR system and should be utilized when possible.

II. Prescriptions, which are printed and emailed: Gilead requires that any prescriptions, which are manually printed, contain the original signature of the doctor on the prescription; regardless of whether the prescription contains all information. Only prescriptions, which are automatically generated and sent from the EMR, are exempt.

f) Documenting Supervision

I. Supervising Physicians must use the EMR to document provider supervision of a Student, Resident, and/or fellow.

g) The EMR must be signed (through Authentication) by the user. The electronic method for authenticating the EMR is established by the use of a unique password, known only by the individual user. All entries and final viewable/printable documents will contain the name and credentials of each individual user.

h) The final generated document that is electronically signed and locked is Gilead Medical official health (medical) record.

Responsible Party: Clinical Faculty, Clinic Staff

5. **Timely Completion of EMR**

a) The doctor or provider will complete patient progress notes on the date of service or within 96 hours of the encounter creation time.

   Responsible Party: Clinical Faculty

6. **Documents that need to be scanned into the EHR:**

a. Documents that need to be scanned into the EHR system will follow the Document Identification Classification Grid for ICS.

b. Clinical staff will print the patient's medical record number (MRN) bar code sheet and appropriate document type barcode sheet.

c. The MRN Bar Code sheet must be placed as the top sheet, followed by the ICS Document Type Bar Code Sheet and then relevant pages(s) to be scanned.

d. All documents classified as a Patient Business Record (Receipts, Bills, Invoice, Treatment Plans) according to the Document Identification Classification Grid for ICS must have a printed Patient barcode sheet in front of all documents.

e. The paper documents prepped should be brought to Records and Information Management by designated clinical staff, at the end of each business day. The

documents received for scanning should be available for viewing in the patient's EMR within 24 hours of Records and Information Managements receipt of documents.

Responsible Party: Clinic Staff, Records & Information Management Staff

7. **Maintenance of EHR**
   a. Patients who have an established EHR record: Prior to a scheduled appointment, each clinical department will be responsible for insurance verification and patient demographic review on their patients who have an established EMR record.
   b. Copying Documents into the EMR: Gilead Medical is to convert all EHR related documents into PDF and incorporate these PDF documents into the EMR. **Rationale: These documents cannot be changed and are read only, making the document more secure.**
   c. Late Entries, Amendments, and Corrections to the EMR: All EMR encounters "lock" within 96 hours of the encounter create time. In the event information is omitted from the EHR, it is acceptable to amend the record. Late entries are acceptable; however, they should be used infrequently. The Health Information Management (HIM) Department must be contacted for all corrections requested for a Locked Encounter. The HIM Department will review all requests.
   d. Correcting data in "Locked Encounters"
      I. This is only for incorrect data, which must be removed from the current record (i.e. wrong patient EHR).
      II. Contact the HIM Department.
      III. An HIM representative will assist with corrections.

IV.   The doctor/nurse will save the incorrect information in the locked encounter as a document, with a statement indicating that the data is not correct.

V.   The records department will then create a "Custom Encounter" for the relevant date of service.

VI.   The doctor/nurse will enter the correct information, indicating that the information being entered is a "Correction and date of correction". The encounter must be locked afterwards.

VII. If charges were submitted for the custom encounter, HIS must be notified regarding the correction to the EMR.

e. Correcting Scanned Documents

I.   In the event a previously scanned document was scanned into the wrong patient's EMR, contact the HIM Department. Provide the patient name, date of birth, and document category, which contains the erroneous document. An HIM representative will investigate the request and follow proper procedure regarding transfer of an ICS image.

f. **Retention of EMRs**: The retention of EMRs will follow the guidelines set forth by the HeFRA, Data Protection Agency of Ghana, NITA and Information Management Department.

I.   The patient medical record, regardless of medium, will be considered active for a period of three years.

II.   In-active patient medical records, regardless of medium, will be destroyed according to the Gilead Medical Records Retention Schedule.

III. Records that require storage beyond the published guidelines will have a department policy established as an addendum to this policy. The addendum policy will be sent to Gilead Medical Records and Information Management for information and implementation.

Responsible Party: Clinic Directors, Clinical Faculty, Clinic Staff, Coding Staff, Health Information Management Staff, Records and Information Management Staff

8. **Laboratory, Radiology, Referral Data**

a) Internal Results of the laboratory tests performed onsite will be available in the EMR system within 24 hours. Designated medical personnel are responsible for entering the results within the time frame into the EMR and notifying the doctor immediately regarding test results that are problematic for the patient and/or outside normal limits.

b) External Specimens to be sent to external laboratories will be processed for pick-up and sent on a daily basis. Specimens will be run on the day of receipt or the following day. High-risk value results will be sent to the appropriate provider through the EMR and/or by telephone.

c) Radiology reports will be available to the referring physician within seven (7) days of the referral.

d) External referrals received will be abstracted and scanned into the EMR.

Responsible Party: Clinical Faculty, Clinic Staff