



PATIENT SAFETY & RISK SOLUTIONS

Using an Electronic Health Record System to Support Quality Improvement

In addition to storing patients' healthcare information, electronic health records (EHRs) offer opportunities to collect and analyze data. These activities are at the core of delivering quality patient care, preventing errors, and minimizing risk. Yet, the challenge for healthcare practices and organizations is understanding how to aggregate and evaluate the data, analyze the results, and develop strategies and initiatives that will help support quality improvement (QI).

QI relies heavily on auditing. Typically, the term "auditing" has been associated with the financial aspects of business. However, ongoing validation of clinical information through auditing also is important from both continuity of patient care and risk perspectives. The following checklist can help guide healthcare providers in using EHR systems to enhance auditing and QI activities. Learning how to make the best use these systems may increase patient safety and satisfaction, reduce the likelihood of billing issues and/or fraud allegations, and support reimbursement.

	Yes	No
Electronic Health Record Systems		
If you are considering an EHR upgrade, or you are purchasing an EHR system for the first time, has your practice talked with potential vendors to ensure obtaining the optimal features that support quality monitoring and risk reduction?		
Does your practice review with the healthcare team the original objectives for implementing an EHR system?		
Does your practice have working knowledge of the data elements and definitions associated with its EHR system?		

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	Yes	No
Quality Improvement Committees/Auditing Processes		
Has your practice established QI committees that meet routinely and report back to staff about activities and progress?		
Does your practice have an audit policy, and is it using auditing to identify areas for improvement and develop action plans?		
Does the entire healthcare team — including healthcare providers, clinical and administrative staff, and staff members responsible for EHR implementation and maintenance — participate in audits to ensure the best audit design and patient outcomes?		
Are quality measures clearly defined so that more than one person can produce the measure results without difficulty?		
Does your practice establish a goal for each quality measure to determine whether the measure is relevant and whether the information gathered will be useful?		
Does your practice establish a target (numerical value of a quality metric) to determine the significance of the actual audit results?		
Are the following considered when establishing the target:		
 Evidence-based literature related to the specific measure? 		
 Knowledge of "best practice" results in comparable settings? 		
Historical data within your healthcare practice?		
 Knowledge of external requirements (e.g., pay-for-performance benchmarks)? 		
Does your practice have an audit document that includes the measure, the definition of the measure, the goal, and the target compliance number or percentage?		
Does your practice consider the method that it will use to obtain necessary data?		

	Yes	No
Quality Improvement Committees/Auditing Processes (continued)		
Does your practice determine how often to measure metrics and monitor results?		
Does your practice consider what steps to take to improve the results if your target is not met?		
Quality Measures		
Has your practice selected quality measures based on high-risk aspects of patient care, such as:		
 Appointment processes, including time from request to appointment and cancelled/missed appointments? 		
 Patient encounters, including chief complaints, problem lists, patient/family history, copied/pasted health information, creation of new patient records, and confirmation of patient identification? 		
 Patient communication, including patient reminders and patient education? 		
 Medication management, including medication reconciliation, drug interactions and allergy alerts, prescribing/e-prescribing, sample medication distribution, and state prescription drug monitoring program queries? 		
 Information management, including release of protected health information and identification of amended or incomplete health records? 		
 Test result management, including test result tracking and referral tracking? 		
Audit Reports		
Has your practice identified the range of reports that its EHR system can generate to help audit the effectiveness and efficiency of processes?		
Has your practice worked with its EHR vendor to automate as many reports as possible and ensure that quality measures are accurately calculated?		

	Yes	No
Audit Reports (continued)		
If data cannot be automatically calculated and manual calculation or counting is required, does your practice specify appropriate sample sizes for various measures?		
Do all providers and staff members understand that the practice's privacy and confidentiality policies apply to all auditing activities, including the generation of reports?		
Analysis, Communication, and Improvement		
Does your practice conduct ongoing analysis of both the audit framework and the audit results?		
Has your practice determined key questions to consider when analyzing audit results, such as:		
 Are we getting better or are we getting worse? 		
Can we see the effect of our latest action step(s)?		
Where are we compared with our established target?		
Has your practice determine how best to display audit results for both analysis and subsequent communication?		
Does your practice have a positive communication strategy for sharing aggregate and individual results from audits?		
Does your practice use the data collected during auditing to develop action plans and monitor the results of corrective actions?		

Resources

For more detailed information and examples of audit measures, see MedPro's guideline *Using an EHR System as a Quality Improvement Tool in Your Healthcare Practice*. Other helpful resources include:

- Agency for Healthcare Research and Quality: Using Health Information Technology to Support Quality Improvement in Primary Care
- The Office of the National Coordinator for Health Information Technology: Capturing High
 Quality Electronic Health Records Data to Support Performance Improvement
- The Office of the National Coordinator for Health Information Technology: Health IT Playbook
- The Office of the National Coordinator for Health Information Technology: How Will Adopting Electronic Health Records Improve My Ability to Care for Patients?
- U.S. Department of Health and Human Services, Health Resources and Services Administration: Managing Data for Performance Improvement

This document does not constitute legal or medical advice and should not be construed as rules or establishing a standard of care. Because the facts applicable to your situation may vary, or the laws applicable in your jurisdiction may differ, please contact your attorney or other professional advisors if you have any questions related to your legal or medical obligations or rights, state or federal laws, contract interpretation, or other legal questions.

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