Authentication in EHRs

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Group Health Cooperative (GHC) is an integrated healthcare system with 29 primary care clinics, four specialty centers, two hospitals, 10,000 employees, and 700 physicians. GHC serves 540,000 patients across Washington state and northern Idaho.

In 2003 GHC began implementing an electronic health record (EHR) system in its ambulatory care clinics. HIM expertise during planning and implementation phases helped educate organization leaders and sponsors about the importance of creating and maintaining a legal EHR. Authentication of transcribed documentation in the EHR processes was particularly important.

Policies

Authentication is the tool that addresses the complete and accurate medical record. It consists of identifying the authorized individual providing the documentation and assigning responsibility for the care and its subsequent documentation. GHC's operational policy established a standard for authentication of documentation in accordance with community and accreditation standards, as well as GHC's evolving technical capabilities and state and federal laws.

Procedures

With the EHR implementation, GHC changed its routing of transcribed notes such that dictated notes, once transcribed, are forwarded to the provider's online in-basket folder labeled "transcription." Dictation procedures remain the same. Once authenticated, the transcribed note leaves the providers in-basket and is displayed in the patient's EHR.

Preliminary notes can be reviewed prior to authentication by accessing the patient's EHR. These notes display a header across the top stating, "This document has not been authenticated. Draft copy--this document is not available for patient care."

Once the preliminary transcribed note appears in the folder, the provider has three options:

- Review and accept the note, which changes the status of the report from preliminary to authenticated
- Review and edit the note, following which the provider accepts the note, which changes the status from preliminary to authenticated
- Review and determine that the note cannot be easily edited, whereupon the provider sends a message to transcription allowing redictation of the note, and the process begins anew

If transcriptionists cannot understand something the dictator says, they place asterisks in that space. The provider then replaces the asterisks with the appropriate terms. If for some reason during the review process the provider misses the asterisks and tries to accept the report, an error message appears.

GHC developed detailed procedures for the providers to access, review, and edit transcribed notes in their transcription folder. This procedure was used to train providers.

The organization recommended that all notes be authenticated within 24 hours of receipt in the provider's in-basket transcription folder; however, it is acceptable if authentication takes place 48-72 hours following receipt.

Providers planning to be away from the office for more than 72 hours are urged to authenticate all preliminary notes in their transcription folder (especially urgent care and emergency departments). Providers have the ability to authenticate transcribed notes remotely via the Internet. Most internal providers comply with the 72-hour turnaround.

Only the original author may authenticate preliminary notes, unless there are extenuating circumstances (e.g., the original provider has left or is on extended medical leave). In these instances, the service line chief (e.g., ophthalmology, cardiology,

orthopedics) or medical center chief is responsible for reviewing the note's clinical content and adding a statement such as "This document was originally created by [provider's name]. This provider no longer works at GHC or is on extended leave [as appropriate]. Therefore the original author cannot authenticate the documentation supporting this visit. This document has been reviewed by [reviewer's name]." The reviewer then documents appropriate follow-up based on the note and the patient's health record (e.g., "no further action is required" or "patient will be contacted by [name, department, date] for follow-up").

Communication

At the outset of implementation GHC circulated a document to clinic managers and providers outlining which transcription and authentication processes stayed the same and which changed.

In July 2003 transcribed notes began routing to the providers' in-baskets. At that time, providers could only read information that had been interfaced from legacy systems. The first primary care clinic became fully implemented in September 2003. Thereafter, each clinic transformed from "read only" to fully functional. Once a clinic became fully functional, no paper copies of transcribed notes were printed or distributed in that facility.

An unauthenticated transcription report is produced on a weekly basis and sent to the managers of each GHC clinic. The report notes the number of preliminary transcribed notes awaiting authentication in each provider's transcription folder. Clinical leaders work with individual providers if it appears that authentication is not occurring in a timely manner.

The last five primary care clinics became fully functional in August 2005, and since that time, GHC no longer prints copies of transcribed notes for primary, specialty, or hospital-based services for patients. GHC is one step closer to becoming a paperless healthcare organization.

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