



GCC-HIMSS 2009 Fall Program



“Meaningful Use – Just Do It”

Presented by:

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Health Information Management Department



- **Current Role**
 - Discharge Processing (5.0 FTE's)
 - Transcription (4.0 FTE's)
 - Document Imaging (17.0)
 - Systems/Applications support (3.0 FTE's)

Medical Center Volumes

(Visits)

- Scanning:
 - Inpatient: 1,600/month
 - ER: 4,500/month
 - Surgicenter/OBSV: 700/month
 - Ambulatory: 36,000/month
- Transcribed Reports: 7,500/month
- Release Requests: 2,000/month



Current Initiative



- Upon request provide patient with an electronic copy of their discharge instructions and procedures at time of discharge
- Upon request provide patient with an electronic copy of their health information (including lab results, problem list, medication list, allergies, discharge summary, and procedures)
- Capability to exchange key clinical information (e.g. discharge summary, procedures, problem list, allergies, test results) among providers of care and entities authorized by patients electronically
- Accommodate patient's request on disclosure restrictions on TPO regarding health information on health services the patient paid for in full out of pocket



Solutions



- Install Content Writer for both inpatient and ambulatory areas; collaborating with ROI vendor to assist with creation of electronic media
- Install Cerner's Clinical Reporting "XR" (extensible reporting) and Health Connections portal; we also have an option to work with ROI vendor
- Utilize secure e-mail, extend the usage of Cerner's PowerOutreach, and implement **Continuity of Care Document (CCD)**
- Revise policies/procedures to include electronic tracking and capture of current patient restrictions on TPO disclosures