Improving Allergy Documentation

The Problem

An audit to assess documentation rates of allergies, medication list and problems list in the electronic medical records revealed a below-standard allergy documentation rate. To eliminate this gap, the hospital Information Technology Department helped the Division of General Medicine to develop an electronic reminder system.

Aim/Goal

To improve the Division of General Medicine and Primary Care documentation rate of allergies

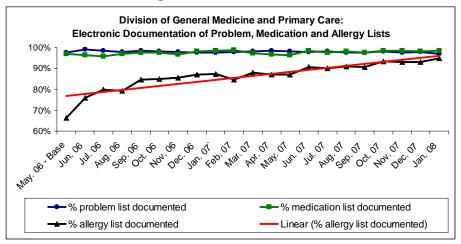
The Team

- Gila Kriegel, MD, HCA, Director of Quality Improvement
- Russell Phillips, MD, General Medicine Chief
- Hans Kim, MD, HCA, Co-Director of Quality Improvement
- Naama Neeman, MSc, Medicine, QI Specialist
- Members from the Department of Information Technology
- Mark D. Aronson, MD, Medicine, Vice Chair for Quality

The Interventions

- Performed an audit to assess documentation rates of allergies, medication list and problems list in the electronic medical records;
- Developed an electronic reminder system for allergy documentation;
- Conducted an on-going audit to assess improvements in documentation rate;
- Provided performance feedback to clinicians at the HCA QA Committee meetings as well as via emails and presentations at faculty meetings.

The Results / Progress to Date



Lessons Learned

Adding an electronic reminder system to the outpatient electronic record increased the allergy documentation rate from 66% (May 2006 - Base) to 95% (Dec. 2007; n = about 700 audited charts per month) for patient seen in the primary care clinic.

Next Steps/What Should Happen Next:

A goal of 100% allergy documentation has been set for FY08. In addition, following the successful implementation of this feature, the Division of General Medicine and Primary Care is now implementing a similar electronic reminder system for missing notes.

