OP Data Cleanup

Last Modified on 07/28/2021 3:43 pm EDT

OP sets **all defaults to share all information** Any individual decisions by Practice-users to restrict information sharing (access, use, or exchange) are the responsibility of the Practice in the implementation of its 21st Century Cures Act Information Blocking policies and procedures for its Practice and patients.

OP Data Cleanup

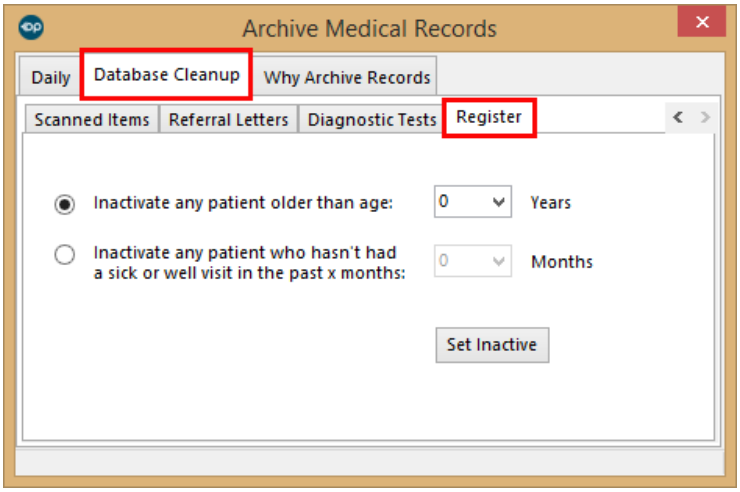
For many reasons, including clinical accuracy, medical-legal protection and OP system performance, it is important that practices work hard to process and document all new clinical information on a daily basis. It is equally important that practices take a high-level look at incomplete work and irrelevant information and routinely archive unnecessary information through a process known as *data hygiene*.

For example, if a staff member leaves the practice, and they are not properly inactivated, then every time a message is sent to their department, they will receive a message delivery to which they will not be able to read or respond. Another common example is practices that had a data conversion and brought information on all of their former patients who initially appear Active in OP, despite the fact they are 30 years old and moved across the country years ago.

If practices are uncomfortable about archiving notes instead of finalizing them individually or marking a message from three years ago as read, they should consider creating a policy and procedure for your office about data maintenance and articulate why, when and how you are doing this. Much like your employee manual, a regular documented procedure helps in cases of dispute.

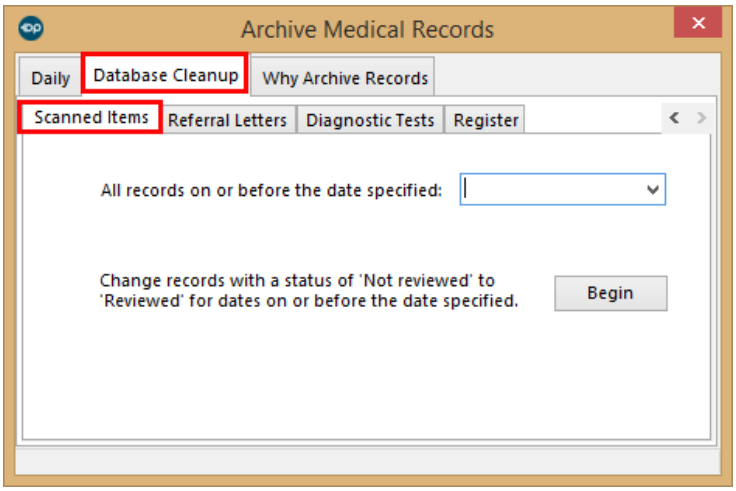
You should perform the following steps now to optimize your OP performance, then have a dedicated person perform similar maintenance at least quarterly according to your practice agreed upon preferences. More information about how to archive records is available here.

1. Validate your *active patient* list. Every time you run a recall or you make decisions about how many patients you serve, you should only use those who truly are active. OP allows you to sweep patients to an Inactive status based on age and the most recent visit to your office. Parameters will vary by practice, but the most common are 21 years of age and at least three years since last visit. Note that if you have adult staff in your system, they may be inactivated by this process, but can still be found to administer flu vaccines, etc. Also, notice that the parameters around last visit (sick or well encounter, or a vaccine that was administered from your vaccine inventory) are calculated in months. The best practice is to do this for both radio buttons to maximize your accuracy.

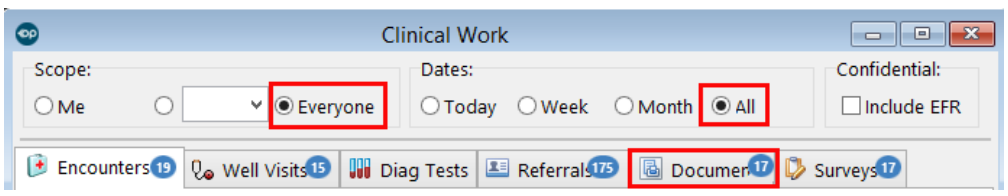


2. Ensure that all of your staff/team members who no longer work in your practice are deactivated in the staff directory, not just inactivated in the address book.

3. Archive old scanned items that are not marked as Reviewed. Practice team members are not going to go back and review scanned items that are more than 3-6 months old. The information remains in your system when you mark them reviewed and the audit trail reflects that this was done as part of the archival process.

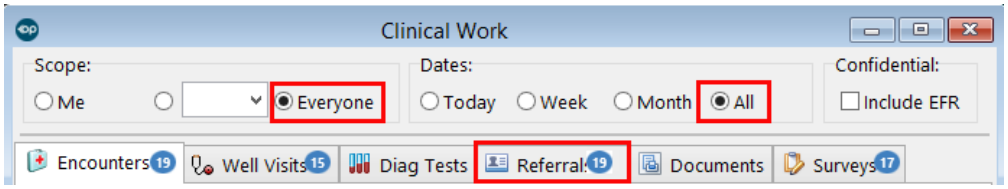


As part of this clean-up process, you may uncover you have significant numbers of scanned images that are not marked reviewed. By doing a root cause analysis using the Clinical Work form, you may uncover gaps in your workflow that need to be addressed. Archiving can take awhile, and it performs a lot of database activity. Do *not* run it in everyone/all mode while providers are trying to see patients. If you have significant amount of unfinished work, this will temporarily slow performance for all users in your system. Is there a particular provider that never marks their documents as reviewed? Is your workflow for providers to initial/date paper reports then scan them, but staff always forgets to select the box for Reviewed and who reviewed it?



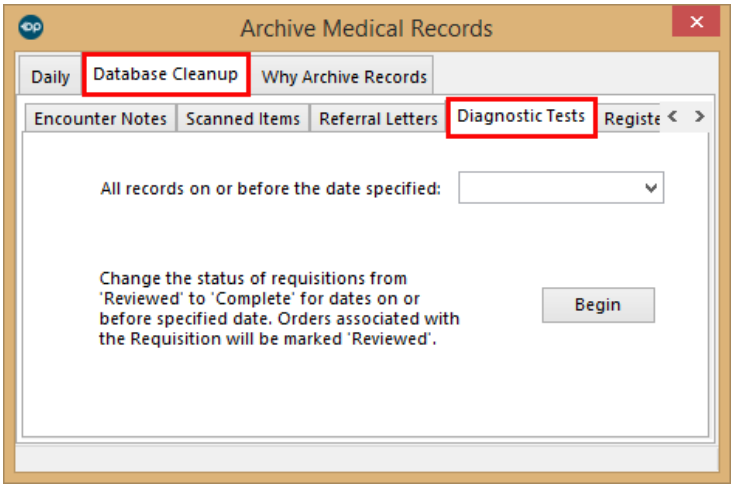
4. Archive the Referrals for which you no longer expect to get a report. Conduct a deeper dive on your outstanding referrals,

use the Clinical Work form in Scope: Everyone, All (do not do this during office hours if this is very large). The Clinical Work form only displays referrals that have reached their anticipated response/flag date. Do not include referrals for which you do not yet expect a report - do not select the include prior to flag date checkbox for this work.

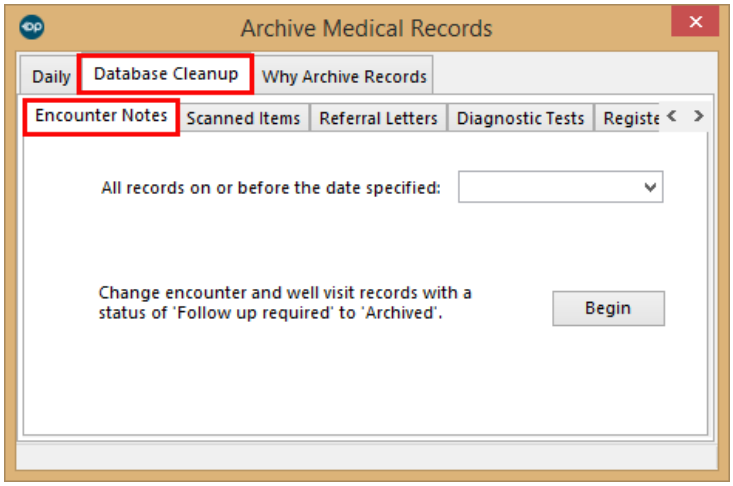


In reality, you may send patients to the dermatologist for whom you do not expect a report back for a year. The best practice is that when the referral is created, the practice team member sets the flag date appropriately. If your team is not diligent about that, you may want to make your date in the archival query for referrals be at least a year old. You may also then want to work to change your default setting or work with team members to set realistic flag dates.

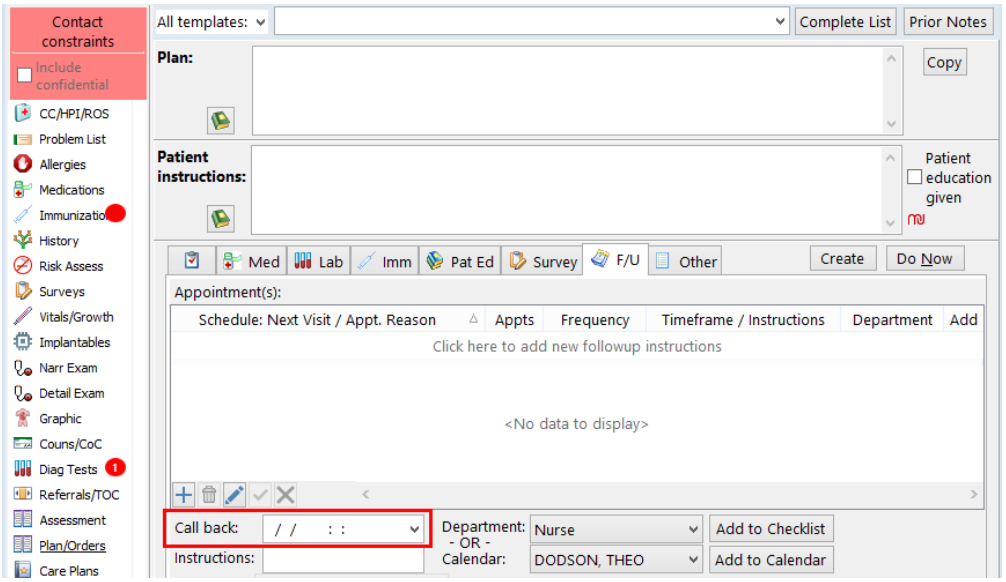
5. Complete diagnostic tests (change requisition stage from Reviewed to Complete) for requisitions which remain in the reviewed stage. In general, if results are reviewed, it means that your workflow does not stage labs to informed/complete, or someone spoke with the family and forgot to go back and stage these reviewed labs to complete. It is unlikely that you are waiting for more than 1 month for a parent to return your call to discuss a diagnostic test result. This will not affect diagnostic tests that you ordered, but have not yet received a report on (or a result for) but they have not yet been reviewed by someone on your practice team.



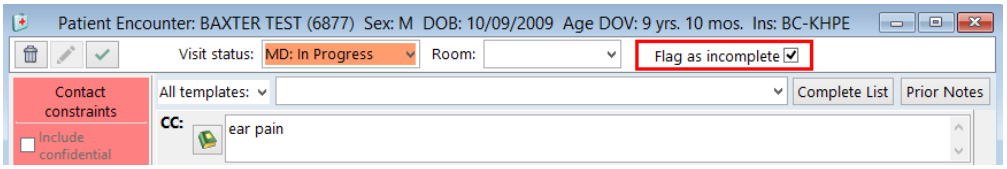
6. Archive notes with *follow-up* which are older than a specific date. At the time you wrote the encounter, if the follow-up status was *call back* or *note incomplete*, this process sets the callback status to No Callback Required and deselects the Incomplete status for the visit as a whole. Note: Those *incomplete notes* were skipped by auto-finalization and they will be finalized the next time you auto-finalize. In general, if someone has not performed a follow-up within 3-6 months of the visit, it is unlikely to happen.



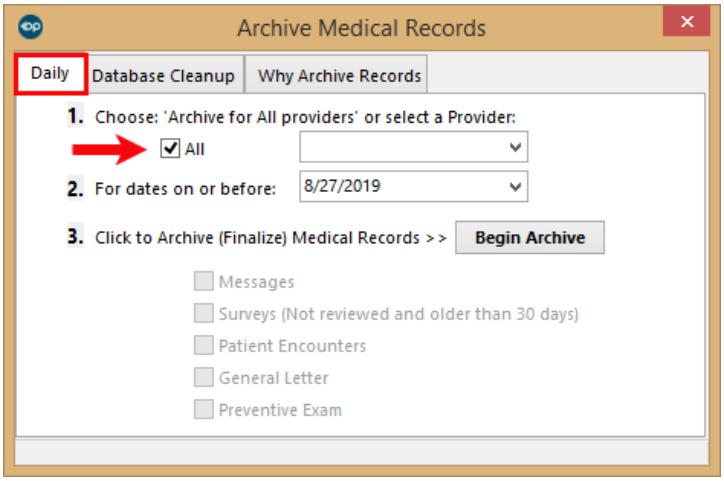
The follow-up encounter archival function refers to the F/U section of the Order Worksheet in the Plan of encounter and well visit notes where callback instructions were included.



Incomplete refers to notes where someone used the checkbox at the top of the encounter to indicate the note was not complete.



7. Regular maintenance should be done on the Daily tab of archiving. Depending on the size of the practice, the best practice is to perform this function either weekly or every other week. A larger practice may elect to perform it daily, just with a trailing date of anywhere from one week to one month. It's important to understand the entirety of what happens when you click the Begin Archive button. The parameters you can select from include all providers or individual ones, and the reference date for which you want to archive records. All of these will be marked as reviewed by the logged in user performing the process when you run this for all. If you do this for an individual provider in step 1, it will make the reviewer the provider selected.



- Messages: Based on historical message archiving, has no practical impact in current OP
- Surveys: For all surveys which were administered longer than 30 days prior to the date in 2. above, where the reviewed date is blank, will mark them Reviewed as of the date you are running this process.
- Patient Encounters: Any unfinalized encounters written prior to the date above (in this case 7/29/19) will be marked as finalized and exit notes will be created. (The documented person finalizing depends as above on whether you chose a single provider or all.)
- General Letter: Archives any general letters written for any patient so they are no longer editable.
- Preventive Exam: Any unfinalized encounters written prior to the date above (in this case 7/29/19) are finalized as described above for Patient Encounters.

THE INFORMATION CONTAINED HEREIN IS THE CONFIDENTIAL, PROPRIETARY PROPERTY OF OFFICE PRACTICUM. ANY DUPLICATION, DISCLOSURE OR TRANSMITTAL OF ANY OF THE CONTENTS OF THIS DOCUMENT TO OTHERS IS PROHIBITED WITHOUT EXPRESS WRITTEN PERMISSION.

This publication is intended for informational purposes only. While we've tried to be accurate, the matters discussed herein are continuously subject to change and may or may not be applicable to the reader's individual situation. We make no guarantee or warranty as to the accuracy of the information contained herein. It is not legal nor regulatory advice as the application of the law and regulations depends on the particular circumstances of each situation. Therefore, the contents of this publication should not be relied upon for personal, medical, legal, business or financial decisions. Readers should refrain from acting, or omitting to act, on the basis of any discussion contained in this publication without first consulting an appropriate professional for specific advice tailored to their particular circumstances. We disclaim liability with respect to any such action or inaction in reliance upon the contents of this publication.