

EHR BEST PRACTICES FOR HIM

RPMS-EHR

Electronic Health Record

Originally developed by :

Emmanuel Y. Yennyemb, MBA, MCP, CSAP, CAC
EHR Implementation Project Manager at Kimaw Medical Center
and CAC Mentor for the California Area Office.

Session Objectives

At the end of this session, participants should be able to understand:

- Best practices for HIM professional using the Electronic Health Record are a set of functions chosen for their representation and recognized in various EHR definitions proposed by key industry groups as well as those in which HIM professionals would most likely have a key role.
- Issue related to incorporating medical transcription and voice recognition into EHR templates and process, workflow processes for HIM professionals that focus on notification management, redactions and more.
- Key components of the EHR such as the release of information, the management of notes for disclosure, the use of an EHR committee and the functions of the committee, and the archiving of an electronic record.

Specific Learning Objectives:

- Contributing factors and processes to best outcomes in all functional areas that HIM professional contribute.
- Working toward best practices throughout the health care field to improve patient care and maintain a secure, accurate, reliable health record system
- Foster benchmarking practices and metric reporting that will enhance best practices research for the next generation in other types of settings and practices in healthcare.

Definition of Best Practices

- “Implemented programs that meet or set new standards or introduce innovations in the management of health information . These practices have been benchmarked and tested, and outcomes have been measured, evaluated and documented.” (AHIMA, 2003)

Measuring Best Practices: Metrics

- The following EHR functions defines outcomes and best practices:
 - Electronic dictation support
 - Results reporting/review
 - Electronic document management system
 - Patient care charting
 - Electronic medication administration record
 - Computerized provider order entry
 - Health information exchange
 - Personal health records
 - Data mining

From: Best Practices in Electronic Health Records- AHIMA

Best Practices Metrics

- Electronic dictation support:
 - Digital Dictation (Medical Digital Dictation)
 - Speech recognition (Dragon Naturally Speaking)
 - Electronic signature authentication
 - Use of Templates
- Results reporting/review
 - Trending/graphing capability and or view only (Vital signs/Lab results)
- Patient Care Charting
 - Free text note and/or template entry with data objects pulled into the note/template (nursing assessment, physical exam, labs...)
- Electronic Medication Administration Record (EMAR)
 - Bar coding/RFID
 - Electronic forms
 - Computer generated paper forms

From: Best Practices in Electronic Health Records- AHIMA

Best Practices Metrics (Next)

- Computerized Provider Order Entry (CPOE)
 - All orders or medication orders
 - Full set of reminders and alerts
 - Order checks set to mandatory for the following: Allergies Unassessible, Allergy-Contrast Media Interaction, Allergy-Drug Interaction, Critical Drug Interaction, Dangerous Meds for Pts >64, Estimated Creatinine Clearance, Glucophage-Contrast Media, Glucophage-Lab Results, No Allergy Assessment, Renal function Over Age 65. (Ref. MU)

From: Best Practices in Electronic Health Records- AHIMA

Best Practices Metrics (Next)

- Health Information Exchange (HIE)
 - External sources
 - Use of secure provider portal
 - Email, or patient – carries device
- Personal Health Records
 - Patient may contribute information to their health record
 - Access information from their health record
 - Obtain health education information
 - Update their demographic and insurance information
 - Request and/or change an appointment
- Data Mining
 - Development of site specific electronic or paper-based clinical guidelines/protocols
 - Quality improvement and executive decision support

From: Best Practices in Electronic Health Records- AHIMA

HIM Best Practices

- Electronic Document Management System (EDMS)-
(Workflow, search and retrieval of document, scanning, faxing and more)
- Patient care Charting
- Electronic Medication administration record (EMAR)
- Computerized provider order entry
- Data Mining

From: Best Practices in Electronic Health Records- AHIMA

HIM Practice area contributing factors (1 of 2)

- Audit compliance with clinical guidelines or protocols
- Audit compliance with clinical decision support alerts and reminders
- Audit that changes in electronic documentation have been made correctly (Vista Imaging scanning)
- Manage the data dictionary for changes to definitions of terms in a controlled vocabulary
- Design/modify screens/templates
- Design/revise reports
- Manage access controls in the EHR system
- Test the legal admissibility of records, including their replication on paper, retention, and durability

From: Best Practices in Electronic Health Records- AHIMA

HIM Practice area contributing factors (2 of 2)

- Manage amendments to records
- Participate in a documentation improvement program
- Participate in a quality improvement program (such as Six Sigma, balanced scorecard, others)
- Serve on the EHR steering (or comparable) committee
- Serve as project manager or on a project management team for an EHR project
- Participate in the development of EHR functionality specifications
- Lead or participate in data standards adoption and implementation

From: Best Practices in Electronic Health Records- AHIMA

Daily Work Process for HIM (1 of 3)

- Develop and oversee processes in the HIM Department:
 - Making sure processes and controls are evaluated against organization's internal and external information needs on an ongoing basis
- Actively participates in various committees:
 - Medical Staff/Medical Records Committee
 - Hospital/clinic-wide Performance Improvement Committee
 - Documentation Improvement Committee
 - Enterprise-wide Electronic Health Record related Committees
 - Patch install
 - Upgrades
 - Security Analysis
- Initiating, reviewing, implementing, and maintaining contracts with vendors for outsourced HIM services

Daily Work Process for HIM (2 of 3)

- Actively move forward from paper based health record to a fully integrated electronic health record environment.
- Ensure that information systems support current and future needs of the department:
 - Work with Information Technology in transition planning
 - Testing, installation, education of staff to produce and maintain high quality data integrity.
 - Work with risk management
 - Legal counsel
 - Administrative staff
 - Ensure that the organization has and maintains:
 - Appropriate compliance including privacy and security and confidentiality policies, procedures, forms/templates, information notices.
 - Materials which reflect current organizational practices and regulatory requirements.

Daily Work Process for HIM (3 of 3)

- Instrumental in form/template design for the electronic health record:
 - HIM professionals should be working actively with IT to develop forms/templates to enhance high quality data collection
 - Ensure compliance with external agencies and state and federal regulations
 - Develop, maintain, and implement policies and procedures
 - Evaluate and improve the effectiveness of policies and procedures and workflow
- Responsible for health information management issues:
 - Release of information,
 - confidentiality,
 - information security,
 - information storage and retrieval,
 - record retention as well as authorship and
 - authentication of health record documentation, standardization of medical vocabularies, and use of classification systems

Preparation for archiving an electronic record to a Federal Records Center (FRC)

- Organizing your records for transfer:
 - Completing, submitting, and receiving approval for the Standard Form 135.
 - packing and labeling your boxes and pallets
 - sending your shipment to the FRC
 - and retaining appropriate documentation
 - separate the record series having the same disposition authority records into series.
 - Identify and separate your records into series by records schedule item number and cutoff date.
 - Each series will be handled as a separate transfer
 - Each transfer must consist of at least one box and normally only one closing year date for a series of records.

Preparation for archiving an electronic record to a Federal Records Center (FRC)

- Understanding Series and Transfer vs. Accession
 - A **series** is a block of records having the same disposition authority and same disposition date.
 - **Transfer vs. Accession** Transferring refers to moving records into the physical custody of a NARA Federal Records Center. The transferring agency retains the legal custody of transferred records until final disposition.
 - When permanent records are **accessioned** into the National Archives NARA takes legal custody of the records, and in most cases takes physical custody of the records as well. Accessioned records become the property of NARA.
- Information on the FRC is available [online](http://www.archives.gov/frc) (www.archives.gov/frc). The web site links to forms, web sites of local FRCs, Federal regulations, staff contacts, and other key information.

REFERENCES

- AHIMA: <http://www.ahima.org/ehim/bestpractices.aspx>
- Amatayakul, M., Work, M., (2006). Best Practices in Electronic Health Records. American Health Information Management Association.
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_032055.pdf
- Federal Record Centers:
<http://www.archives.gov/frc/toolkit.html>
- IHS: <ftp://ftp.ihs.gov/pubs/EHR/HIM+BO/>

Presenter contacts

- Emmanuel Yennyemb, MBA, MCP, CSAP, CAC
K'ima:w Medical Center, Hoopa, CA
Phone: (530) 625-4261
Cell: (252) 412-5730
E-mail emmanuel.yennyemb@kimaw.org or
E-mail eyy0625@gmail.com

Questions & Answers

- **THANK YOU**