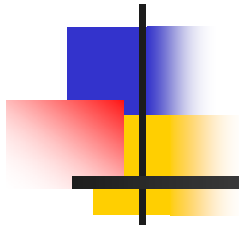


Release of Information Framework in the Hybrid Record



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Planning

- Organizational Strategy
 - Decision to purchase/build an e-hr
 - Functionality of the e-hr
 - Direct data entry
 - CPOE
 - Interfaces to other clinical applications
 - Integrity of the data
 - Phased approach versus all at once



Implementation Team

- Key members
 - MD's
 - RN's
 - Ancillary Services (lab, radiology, pharmacy)
 - Health Information Management
 - IT
 - Project Manager



Resources - Teams

- IT Steering Committee
- Implementation Team
- User Team



Issues to Consider

- Clinical
- System functionality
 - Vanilla
 - Customized
- Integrity of the data
- Legal/risk management
- Revenue cycle
- What happens during planning is what you will get when releasing information ⁵



Inventory of Existing Data Sources – Clinical Information

- Identify what electronic data you have
- Niche data base (individual workstation)
- Identify source system
- Identify system of record
- What will be interfaced to the e-hr
- What may be interfaced to the e-hr



Inventory (con't)

- Identify stand alone clinical applications
- 'wish list' of stand alone clinical apps and ability to interface to the e-hr
 - MUSE (ekg's)
 - Fetal monitor strips



Create a Matrix

- Identifies all clinical applications
- Source systems
- Systems of record
- Identify which system for ROI
- Share with implementation team
- IT Steering Committee



Scanning

- Identify what paper needs to be scanned
 - Historical – how far back
 - Define 'pertinent pack'
 - Define 'start date'
 - Indexing
 - Keep or confidentially destroy after scanning



Clinical applications - interface

- Not all users will want to see everything
- Implementation team and users need to discuss location of information
 - Value of clinical information being available
 - Location in e-hr of that information
 - Creation of tab/specific location
- If all clinical information in one location ROI staff only have to access one application



Understand E-hr Functionality

- Authentication of transcribed notes
- Authentication of ancillary reports
- Copy/cut and paste
- Correction/addendum
- Formatting – electronic versus paper
- Location of documents within e-hr



E-hr Functionality

- Unauthenticated transcribed notes
- Saved versus signed
- Encounters opened in error
- Addendum functionality
 - When used
 - By whom
 - How to identify
- Encounters not completed within certain timeframe (organization specific)



Electronic Notes

- Unauthenticated transcribed notes
 - Preliminary
 - Final
- Determine if one or both will display
- Determine if one or both will be released
- Organizational policy
 - How long can a note be unauthenticated

Computer Screen View

Modified Morse Fall Scale		
Must be completed for all patients every shift per protocol.		<input checked="" type="radio"/> Initial Assessment <input type="radio"/> Reassessment
Item	Scoring	Scale
History of Falling - immediate or within 3 months	<input checked="" type="radio"/> No (0) <input type="radio"/> Yes (25)	No - 0 Yes - 25
Secondary Diagnosis	<input checked="" type="radio"/> No (0) <input type="radio"/> Yes (15)	No - 0 Yes - 15
Mobility Aid	<input checked="" type="radio"/> Independent (0) <input type="radio"/> Bedrest - Nurse assist (0) <input type="radio"/> Cane/Crutches/Walker/Wheelchair (15) <input type="radio"/> Furniture (30)	0 0 15 30
IVF Infusion/Narcotics/Diuretics	<input checked="" type="radio"/> No (0) <input type="radio"/> Yes (20)	No - 0 Yes - 20
Gait / Transferring	<input checked="" type="radio"/> Normal/bedrest/immobile (0) <input type="radio"/> Weak (10) <input type="radio"/> Impaired (20)	0 10 20
Mental Status	<input checked="" type="radio"/> Oriented to own ability (0) <input type="radio"/> Forgets limitations (15)	0 15
Scoring Total		0

RISK LEVEL	FALL SCALE SCORE	ACTION
Low Risk	0 - 24	Good basic nursing care
Moderate Risk*	25 - 50	Implement Moderate Risk Fall Prevention interventions
High Risk**	Greater or equal to 51	Implement High Risk Fall Prevention interventions

*Every 2 hour visualization and documentation on Vital Sign Flowsheet is required for patients on Moderate Risk Fall Precautions
 ** Every 1 hour visualization and documentation on Vital Sign Flowsheet is required for patients on High Risk Fall Pre

Additional Comments	
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NUR 480 PF
Approved 6-28-06



Print Screen View

Patient Name: **zzTest, PatientK L**
MRN: 00585210
Acct#: 8000114000

Attending Physician: Varun Laohaprasit, MD
Ordering Physician: N/A
Copies To: N/A

Morse Fall Scale

Morse Fall Scale Form

05/30/06 02:24 pm Performed by Tarvydas, Helen C

Entered on 05/30/06 02:24 pm

Morse Fall Scale

Initial Assessment
History of Falling Immediate 3 months
Secondary Diagnosis
Ambulatory Aid
IV Saline Lock
Gait Transferring
Mental Status
Morse Fall Scale Total

Initial Assessment
Yes
No
Crutches
Yes
Weak
Oriented to own ability
70



Corrected Print Screen View

Patient Name: **zzTest, Julie**
MRN: 00965046
Acct#: 8000777878

Attending Physician: Physician-QA Test
Ordering Physician: N/A
Copies To: N/A

Morse Fall Scale

Morse Fall Scale Form

03/31/09 08:07 am Performed by Brown, Douglas

Entered on 03/31/09 08:07 am

Morse Fall Scale	Initial Assessment
Morse Fall Assessment	No (0)
History of Falling Immediate 3 months	No (0)
Morse Fall Secondary Diagnosis	Independent (0)
Ambulatory Aid	No (0)
IV Saline Lock	Normal/bedrest/immobile (0)
Gait Transferring	Oriented to own ability (0)
Morse Fall Mental Status	0
Morse Fall Scale Total	0
MF Score	0
Morse Fall Low Risk Reference	Score: 0 to 24 - Low Risk - Good Basic Nursing Care
Morse Fall Moderate Risk Reference	Score: 25 to 50 - Moderate Risk - Implement Moderate Risk Fall Prevention Interventions. Every 2 hour visualization and documentation on Vital Sign Flowsheet is required for patients on Moderate Risk Fall Precautions.
Morse Fall High Risk Reference	Score: GREATER THAN 50 - High Risk - Implement High Risk Fall Interventions. Every 1 hour visualization and documentation on Vital Signs Flowsheet is required for patients on High Risk Fall Precautions.



CIS Process

- Build
- Test
- Print
 - Prefer to have screen/paper format identical
 - At least have all data elements display on both
- Production



Policies and Procedures

- Review existing policies/procedures
- Update/create new policies/procedures
 - Addendum
 - Corrections
 - Late entry
 - Copy and paste
 - Electronic signature



Workflow

- Understand how implementation strategy will impact ROI
- Direct data entry
 - Less paper (maybe!)
 - How do the electronic documents print
 - Who is printing for what purpose
 - Easily retrievable
 - Where in e-hr will the documents display



Formatting of E-hr

- Electronic printed copies to include
 - Name of organization printed on each page
 - City and State (minimum)
 - Patient name and another identifier on each page
 - Confidential water mark or disclaimer on electronic pages printed for patient
 - Discharge instructions



Page Numbers

- Understand how printed page numbers are assigned
 - Direct data entry
 - Documentation
 - Forms
 - Scanned documents
 - No page numbers
 - Entire record when printed may not have sequentially numbered pages
- Explain that at a subpoena



Scanning Outside Records

- Outside organization sent electronic records
- Records received by hospital
- Outside records used
 - Same electronic vendor
 - Format looked identical
 - No organizational identifiers on printed documents (name or logo)



Challenges

- E-hr's may have multiple print options
 - Complete record
 - Summary report of specific service (labs)
 - Summary report of specific episode
- Review and update existing ROI procedures
 - Review/monitor consistency in printing from the e-hr



Chart Order

- It's just as easy if not easier to create a messy electronic record as it is to create a messy paper record
- Users may want the same document in multiple locations
- HIM needs to **own** the management of chart order



Chart Order - Learning

- Multiple locations for documents
 - Radiology
 - Interfaced from IDX – display under DI tab
 - Documents scanned – display under documents tab
 - Creates confusion
 - Providers who only use e-hr infrequently
 - auditors



Planning

- Current work flow
 - Review current paper ROI process

Proposed work flow

- proposed electronic ROI process
- Hybrid work flow
 - Determine what will be paper
 - Determine what will be electronic



Retention

- Depends on work flow/scanning
 - Hybrid model
 - Paper scanned and then stored
 - Electronic model
 - Paper scanned and then confidentially destroyed



Benefits and Risks

- Benefits
 - Scan and store
 - Can retrieve paper records for review
- Risks
 - Scan and store
 - Can retrieve paper records for review
- Benefits versus risk
 - Depends on who you ask!



Risks

- Electronic often looks different than paper when printed
- Question of integrity of data
- Storage/retrieval costs
- Originals may be subject to a court order



Confidentially Destroy

- Established quality assurance process
- All scanned documents reviewed
 - Patient name correct
 - Encounter/medical record number correct
 - Document in correct location within e-hr
 - Document uploaded to e-hr



Learnings

- Paper versus electronic
- Paper – only one way to copy
- Electronic – various ways to print
- Identify consistent process
 - Insurance companies
 - Attorneys
- Cost associated with each page



Definition of Legal Health Record

- Review existing policy of legal health record
- Include hybrid record in policy
- Electronic record in policy
- Definition will depend on your retention policy and procedure



Security Matrix

- Role based access
- Identify who needs access to the e-hr
 - Clinicians
 - Ancillary staff
 - Health information Management - ROI



Role Based Access

- Determine level of granularity offered by vendor
- Work closely with IT Department
- ROI staff need access to ALL records
- Confidential records/pictures (SANE)
 - Limit access
- May be their own role based access
 - read only functionality



Record Integrity

- Accuracy – integrity of the record
 - Error identified in record
 - Audit to see who has accessed the record
 - Ability to block or remove document in wrong patient's chart
- Mitigates the risk of information being inappropriately released



ROI Options with E-hr

- Print to paper
- Electronically fax
- Copy to a CD
- Copy to a thumb drive
- Depends on audience
 - Patient
 - Other providers
 - auditors



ROI Options - Staff

- May have access to multiple clinical applications
 - Hospital
 - Clinics
- Centralize release of information functions
- Consistency
- Compliance with State and Federal law

Remember

Implementation of an e-hr

- It is not an event
- It is an ongoing process
- Changes in functionality occur with upgrades
- Users and HIM needs to understand any changes in functionality
- Changes may impact release of information



Questions -

Thank You

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