

Changing Roles and Responsibilities: Frontline Experts Speak Their Mind

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Changing Roles and Responsibilities When Transitioning from Paper to Bytes

Long before the Institute of Medicine published in 1991 its watershed report, The Computer-Based Patient Record: An Essential Technology for Health Care, the information technology (IT) and the health information management (HIM) professions were on intersecting courses. With President Bush's Executive Order on April 27, 2004, calling for widespread deployment of health information technology, and the appointment on May 6, 2004 of Dr. David Brailer as the first National Health Information Technology Coordinator, that intersection has finally come into view.

Few people doubt that computerizing both personal and aggregate health data will produce tremendous cost and quality advantages for the national health system and improve the health of our citizenry through population health management and disease outbreak monitoring. Similarly, most people recognize that gaining the greatest benefit will require collaboration among the various involved disciplines-clinicians, health information management professionals, and information technology professionals-and perhaps a few role modifications.

To what extent will these role modifications affect today's HIM and IT professionals? And what can we learn from the experiences of the country's most progressive and technologically advanced healthcare organizations? The American Health Information Management Association (AHIMA) and Healthcare Informatics organized this roundtable discussion to find out. McKesson and EMC provided financial support to enable dissemination of the proceedings to the readers of Healthcare Informatics and the members of AHIMA. The roundtable took place on August 17, 2004.

Roundtable Moderator and Panelists

Moderator:
Don Mon, Ph.D.
AHIMA

Dr. Mon is vice president of Practice Leadership for AHIMA, an association of more than 48,000 health information management (HIM) professionals. He leads the association's strategic focus on Electronic Health Information Management (e-HIM). Prior to AHIMA, he served as a chief information officer at The Pritzker School of Medicine, University of Chicago, and helped initiate, develop, and maintain data and information systems for Catholic Healthcare West, Premier, Inc., the Oracle Corporation, and Rush-Presbyterian-St. Luke's Medical Center. He presents regularly at educational events and has published numerous articles on health information management and technology subjects.

Panelist:
Susan Hanson, MBA, RHIA, FAHIMA
TerraStar Consulting

Ms. Hanson is president of TerraStar Consulting Services, an independent consulting firm providing health records, electronic health record (EHR) and healthcare information technology (HIT) services to the global healthcare community. Previously, she was chief operating officer of two major healthcare IT system suppliers, one to the physician market and the other to the hospital and health system market. Prior to that she was director of Patient Data Services at the University of Washington in Seattle. She is a past president of AHIMA and of the Washington State Health Information Management Association.

Panelist:

Donna Bowers, JD, RHIA, CHP
Baylor Healthcare System

Ms. Bowers is vice president of HIM/Medical Staff Services at Baylor Healthcare System, an 11-hospital network based in Dallas. She has system responsibility for the Health Information Management Departments, Medical Staff Services, Care Coordination, Social Services, Clinical Ethics, JCAHO and Regulatory Compliance as well as other clinical and non-clinical activities at Baylor University Medical Center. She was responsible for implementing HIPAA across the healthcare system, is a past-president of the Texas Health Information Management Association, and speaks and writes frequently on information management, HIPAA and other topics.

Panelist:

Ann Sullivan, MBA
Sullivan Consulting

Ms. Sullivan is an independent consultant and former senior vice president and chief information officer at Maimonides Medical Center in Brooklyn, New York, which received the 1998 Computerworld Smithsonian Award for Medicine under her direction. Sullivan and Maimonides subsequently won the 2002 Davies Award for implementing a hospital-wide electronic medical record that 1,600 physicians use in their daily lives. Previously she was regional CFO for the North Bronx Healthcare Network, CFO of Jacobi Medical Center, CFO for Metropolitan Hospital, and CIO of Elmhurst Hospital Center. Jacobi also won a Davies commendation in 1995, under her direction, for exemplary components of EHR implementation.

Panelist:

Lynne Henderson, MHA, RHIA
Spartanburg Regional

Ms. Henderson is corporate director of Health Informatics at Spartanburg Regional Healthcare System, an 11-facility system in Spartanburg, S.C. She holds a Bachelor of Science degree in Health Information Administration and a Master's degree in Health Administration, has 15 years of experience in health information administration and is president of the South Carolina Health Information Management Association. She has successfully implemented electronic health records, acquired extensive knowledge in the security and confidentiality of health information, and has thorough knowledge of the impact that increased efficiency, coding quality and compliance has on the revenue cycle.

Panelist:

Lyle Berkowitz, MD
Northwestern Memorial Physicians Group

Dr. Berkowitz is a practicing internal medicine physician who has worked and consulted in the field of applied medical informatics throughout his career. He is medical director of Clinical Information Systems for Northwestern Memorial Physicians Group, the largest primary care medical group in Chicago, and president of an e-healthcare consulting company. Berkowitz serves on the board of advisors for the Association of Medical Directors of Information Systems (AMDIS), wrote the chapter entitled "Physician Adoption Strategies" for the American College of Physicians' book *Electronic Medical Records*, and frequently writes and speaks on healthcare information technology subjects.

On the Value of EHRs

Mon: The healthcare information technology environment is going to see massive growth during the next 10 years. With the introduction of David Brailer's office we are seeing the electronic health record, or EHR, become a key component of this strategy and perceive that this is an unprecedented period of time for us. All of you on the panel have been involved in implementing EHRs. What benefits have your organizations achieved as a result?

Berkowitz: When they think about the benefits of these systems early on, many people think long term, about decision support and data analysis. But from day one they receive significant benefit in terms of quality, which results from improved access to information.

At our practice we share a database with the hospital. Results of any tests done at the hospital are immediately available at the practice. I don't have to go searching for them or wonder where they are. And any documents I create are available for physicians across our organization.

Access is the number one benefit we see. And legibility goes right on top of that, because access to a bunch of scribbled notes does not help a thing.

We have drug interaction checking, drug allergy and drug/drug checking and have already had experiences where if a patient has an allergy to penicillin and I try to prescribe something in that class, I get an alert. It happens to all of us, so it is nice to have the system checking on us.

Longer term, we hope to leverage the information we have, analyze the data, figure out if what we are doing is successful and start using more decision support capability. We hope over time to improve the cost benefit of these types of systems. Short term, that's a harder analysis to do. The focus is more on quickly improving quality.

Sullivan: We took the time to create an interdisciplinary value metrics committee prior to the purchase and implementation of our EHR systems at Maimonides. We wanted to collect pre- and post-implementation measurements for all applications we installed.

Being a CFO, I was concerned with the cost of these systems and with demonstrating return on investment, or ROI. We used strategic investment models to calculate the cost of electronic records as well as the benefit savings they created. This included traditional cash flow and benefit analysis. Maimonides received a 10 percent return on investment for its electronic records and ancillary systems. That was interesting because it was one of the first times we've seen in this country a fully documented return on investment for EHRs, in the financial sort of way that the green eyeshade folks like to see.

In addition, because of improved information access through Maimonides' inpatient electronic record, we were able to prevent unnecessary and duplicate tests. In the laboratory, chemistry tests decreased by almost 50 percent; urinalysis by 42 percent; microbiology by 40 percent; serology by 8.5 percent and hematology by 6 percent or over 500,000 tests annually. This was at the same time that there was a substantial increase in new admissions and a stable case-mix index. All told, we saw a reduction of 1.5 million laboratory tests a year, and a 20 percent reduction in tests in non-laboratory areas.

We saw a reduction in our average length of stay of over 2.5 days and attributed about 25 percent of those savings to the efficiency of the electronic health record. We saw nearly a 100 percent improvement in transcription errors. And, there were labor savings in transcriptions and file space and no one having to file films and so forth.

On the clinical side, providing decision support at the point of care was successful in guiding physicians to choose lower-cost alternatives. We reduced our pharmacy costs by \$1.1 million a year due to automatic order changes from IV to PO, changes to medication ordering pathways, therapeutic interchange and dosage modifications. Delivery times for medications from orders decreased 68 percent. Problem medication orders decreased by 58 percent and medication discrepancies by 55 percent. Pharmacy transcription errors were eliminated.

With increased appropriateness of care and interventions, we were able to ensure compliance with disease management protocols and also provide quicker access and response to information on the patient's status with decision support and alerts at the point of care. In obstetrics, within nine months after EHR implementation, our malpractice premiums went down by \$1.4 million a year.

Berkowitz: Where I am, in a medical group with a payer mix that is primarily fee for service, a reduction in lab tests, ancillary tests, length of stay and pharmacy costs could cost us money, which is, of course, one of the fundamental problems with our system. One of the main barriers to investing in EHRs is that you can actually lose money by being more efficient and improving quality. You were lucky enough to be in a place that rewarded quality, Ann.

Hanson: When you implement an EHR in a physician practice that is privately owned, the administrative benefits initially outweigh the clinical benefits. In a large 140-physician, multispecialty practice, one significant administrative benefit began to accrue simply through their reduction of chart pulls. That may not seem like a big deal; but if you can reduce chart pulls from a paper medical record room by 50 percent because the charts are online, a number of benefits can be realized, such as:

immediate access and availability of clinical information for prescription refills and referral follow up as well as reduction or elimination of costs related to the pulling and refiling of paper records.

I saw that level of administrative benefit in every implementation. On the clinical side, once the practices were paperless they were able to have a longitudinal view of the patient and identify patterns of care. In one case, they were able to identify a patient who had a recurring problem with headaches, which would never have been identified in a paper-based world. The child had to have head surgery to relieve a life-threatening condition. Had the longitudinal view not been there-with the ability to see and analyze the pattern-that patient would not have been saved.

In most EHR-based practices, physicians could leave the office by 5 p.m., prescription refills were legible, and their overall anxiety with the quality of care was reduced. They no longer worried that "I might have missed something because I didn't have time to read the entire record." Also, the clinical alerts and reminders assisted in assuring a thorough exam and treatment plan.

Another practice, because of having a welldocumented electronic record, was spared from state coding reviews because multiple reviews had been done and the documentation was always there and complete.

The last benefit is ubiquitous access to an EHR. Most of my clients were in an ASP environment, so the chart truly was accessible from anywhere.

Mon: A lot of the benefits that you talked about had to be measured. How did you pre-plan what you were going to measure and how did you get other people involved and focused on those specific metrics?

Sullivan: First of all, we encouraged a literature search by the medical staff and nurses. We helped them identify some of the best work and guided the multi-disciplinary value metrics committee to look at the possibilities. Based on that input, the committee held a brainstorming session to find out what would best represent that clinic's or that department's point of view and what data would be meaningful for them to collect. We asked them to have data collection tools set up so we would have about six months worth of pre-implementation data to compare with the post-implementation data.

Hanson: During the kickoff meeting at the start of an implementation, one of the first questions I ask is, "How will you view success once you have been up and running on the EHR system for three months? What will be your measurement of success?" The value metrics are tailored to the needs of the practice.

In the case of the pediatric practice that no longer had to do coding reviews, their goals were to eliminate the need to ever pull charts again and to eliminate the need for the medical society and state reviewers to come in to check their coding. So that was a big win for them. Additionally, once they were known as the practice in town that had automated records, they saw an increase in their patient population. The consumers were much more comfortable knowing that the record was in an electronic format and could not be lost the way the paper record could be misplaced.

In a private practice it is a bit different because it is their own business. Once they have made the decision to make it work, then the physicians and their employees strive to make it a success. There isn't a thought that we are going to turn back and it's not going to be a success. I found that they spent less time wanting to do hard and fast ROI studies.

Berkowitz: From my perspective, as part of an 80-physician group, it is hard to figure out the ROI to even create an ROI committee.

We knew-our executives knew-that there wasn't going to be an easy short-term ROI, especially in our environment, where quality is not particularly well incentivized right now. We did it because we felt that it was the right thing to do. We are able to see relatively easily how much money we pay in salaries as an organization. If I need one or two fewer billing clerks or filing clerks, now I need to hire an EHR team. And that is much more expensive. Things are not as simple as just looking at the number of file clerks.

We ask, "How much salary per position are we paying to run our practice and any individual office?" Also, "If we can get rid of all the charts and put in a new exam room, how much can I make per square foot of office space?" Those are the things we are looking at; we are just too early in our process to fill in the numbers.

I like the idea that there is a patient loyalty and a consumer aspect, that as people recognize your group has the EHR and there are quality benefits, that you generate more volume and it puts you in a position to possibly charge more to recoup your investment.

Bowers: At Baylor, we felt we needed to have some return on investment figures. So we brought in an outside consultant who met with just about every department within our organization and came back with figures that showed, over a certain period of time, that we would recoup millions of dollars. This was one of the tools we used to get the board's commitment for the money it took to implement something like this in 11 facilities.

Short term, we told the board, there could be an increase in expenses related to startup. There is going to be a change of skill mix that will be needed. So instead of losing a file clerk, you are going to end up with a full-time employee, or FTE, who does scanning. But long term, that's really where the benefits are going to be. Down the road, once you get everything set up, you are going to be able to function with fewer positions.

We got into details such as denial management and how it is going to help us, clinically, working with the insurance companies. Just the access to information that we will have is a tremendous benefit and will save us money. That is one of the ways that we tried to validate the expense and the return on investment.

On Changing Roles

Mon: What has occurred is that we have changed job responsibilities. We don't have a file clerk; we may have either a scanner or a data entry or knowledge-level person, somebody who can make use of the actual data. What other changes have you seen?

Bowers: One of the things we have definitely seen is a difference in skill mix. Baylor Medical Center is about a 1,000-bed facility. In our HIM department we have about 120 FTEs. In that department we have developed sort of a mini information systems department. The skill set we look for are in people who have RHIA or RHIT credentials with an IS background. We have at least five FTEs in that area. Five years ago we didn't have any.

Also, in our information systems department we have dedicated new resources now. We have two to three FTEs over there who spend all their time with HIM working on systems, including the electronic record. Again, at least one of those has an RHIA and a Masters in IS. So we are beginning to see a tremendous shift in skill mix.

Hanson: We always advised practices to recruit people who had some level of computer skills or familiarity with IT.

Often, the bigger issue was to redefine workflow, as it contributed to the type of individuals you needed.

Berkowitz: It is somewhat reassuring to know that there are HIM people working with IT people to figure out the medical record. While some IT people are less than comfortable with their understanding of what a medical record is, HIM professionals are really comfortable with the medical record, have always been very supportive of electronic records, and can see and value the concept of using information technology to fulfill the very goals that they have wanted all along.

Bowers: The RHIAs have the process knowledge and also the regulatory background. Just because you change a medical record from paper to electronic does not mean the regulatory requirements change or go away. So the RHIAs are able to bring in the knowledge and the processes that the IT folks typically don't have, because it is not their background. So the two of them work very closely together and you cannot do it with only one; it is very critical that you have them both on the team.

Hanson: All of the traditional paper-based medical record roles that we have as HIM professionals are necessary in the management of the EHR. Often IT focuses on automating the creation of the clinical encounter, with the functions and features necessary to manage an EHR-based system as an afterthought.

Berkowitz: I see this over and over again. Many companies create an EHR to simply replicate the paper system, which is a mistake.

Hanson: That's true. Some vendors have not gone beyond the encounter, have not provided the functionality necessary to manage the EHR.

Henderson: That's where I think the HIM professional within the facility can work closely with the vendor. That's what we did here at Spartanburg and there are HIM professionals on our vendor's staff. I work with them and we know where we want to go and what we want to do.

On the Need for HIM Expertise

Mon: How does the HIM professional get on the team so that these things can get thought out well ahead of time, all the way into the RFP process or even the project planning process?

Berkowitz: Even if you choose a system that does not have a functionality you want initially, have the HIM professionals involved early on to make sure the vendors are moving in that direction. And when they say, "Yes, we are going to have that," the HIM professionals can make sure they really understand what that means.

Bowers: And often they will have input as to whether or not the issue is a showstopper.

Berkowitz: On the other hand, most small practices, ours included, don't have an HIM professional. I hope what we will see more in the future is hospitals helping their affiliate physicians in these areas, by buying the products themselves and distributing them to affiliate physicians. Because there is no way a smaller group is going to have someone with that type of knowledge.

Sullivan: They can look to the hospital. They can look to a number of organizations out there- AHIMA for one-to put out practice briefs and promote themselves and their capabilities and competencies to physician practices. My experience has been that HIM professionals work with physicians every day. If physicians need assistance in their practice, most HIM professionals will be there to help.

Mon: For those of you who have implemented EHRs or are in the planning process, what is the composition of your project team and what are their insights and contributions?

Hanson: There is no best way to do this. The culture and organization of the practice and the individuals in it dictate the best way for that particular practice. We tended to look at things as "paper-world," "hybrid- or transition-world" and then "fully electronic-world." Because you can't just go from paper to fully electronic; there is that transition or transformation state.

Sometimes, if there is one individual within an organization who is the EHR champion, who can envision daily life in a fully electronic world even though they are not there yet, that person is probably your best candidate to orchestrate the changes necessary to achieve success. When I work with practices, I am always on the lookout for that person. The HIM professional has the knowledge and competencies to take on this role.

In talking with a practice as they were embarking on the journey, it was important to be very up-front about the fact that this is an invasive change, a major transformation. Once you begin it you cannot go back. "Are you really ready?" was a question I always asked.

Mon: Would an HIM professional be well positioned to be a participant in the re-engineering of the workflow process?

Bowers: I wouldn't be surprised if, in some organizations, they facilitated it.

Hanson: I wholeheartedly agree. HIM professionals are experts at all aspects of the management of the clinical data. They understand the workflow of the clinical processes as documented by the health record.

Bowers: The HIM professional understands the documentation from birth through destruction. Everybody else knows where his or her part comes into play. But the HIM professional knows it from the beginning to the very end.

On Making the Transition

Mon: When you are converting from your older systems to the EHR, how do you ensure the quality of the data going into the newer system and how does the project team organize that effort and implement it?

Bowers: The key, the starting point, is the testing. It is extremely important to test every scenario before you go live, as a foundation.

Hanson: And even conducting “mock live” exercises. The same way you do mock Joint Commission surveys, it is best to do a mock live environment on the EHR, even to the extent where all users, clinicians, etc., do one or two cases. Then you do a review session.

Bowers: Before you even get to that step, you should determine if your data are of the quality that you want for the EHR.

Organizations will have to take a hard look to see if these data are worth converting. If for some reason they are, then the mapping is probably the most critical step. Then test, once you have decided what you are going to map. But a lot of these data are just worthless, especially in a converted system because we are not using the same definitions, the same meanings.

Hanson: When I think about data conversion, specifically to the EHR, I think about setting up a demographic file, a medication record, a patient summary, and some level of an acute care visit history. In most cases, when you turn on an ambulatory EHR, it is empty. However, you are converting maybe 30,000 records that are already within that practice. So there are a couple of different ways you can do that. You can scan the entire record and have that scanned document accessible. Or, in the old days prior to photocopiers, when someone asked us for a copy of someone’s medical record, we abstracted the chart. Similarly, when you set up an electronic health record in a physician practice, probably the best thing to do is to abstract that record for the patient’s salient clinical information that is needed on a go-forward basis.

Berkowitz: One of the reasons our group decided to switch over to the hospital lab was because we had been using a very large private vendor, and our pathologist said if that data comes into our new system it would not be the same because they may have different standards. They use different machines. If we did integrate it, which would have been difficult, the data would show up on different lines, so our sodium would not show up on their sodium line.

Mon: You do have those instances where the data just won’t match up.

Hanson: Then it needs to be analyzed at the data element level and definitions made. **Mon:** What kinds of mechanisms were put into place to either plan and analyze on the front end or to measure on the back end and then to rectify and improve data quality throughout the entire process?

Sullivan: If we relate it to data conversion, the best data quality results when the physician is seeing the patient and pulls up the EHR and verifies with the patient the information that is there. Anything that is not verified or is inaccurate is amended at that time. That is fundamental; that happens in the paper world as well.

If you convert data from another system, whether it is paper or electronic, and put them into the electronic health record, the physician and/or the patient needs to participate in declaring the data are of quality.

Berkowitz: There are two aspects to the data. There are the shared nomenclature data that are the lab and meds, where you have strict nomenclatures. Usually you take what the vendor offers.

Then there is the doctor entering data. There is no way to require the doctor to put quality data into the EHR. We told docs, “You are their doctor. You decide what in their paper chart is valuable enough to scan. It’s probably only going to be a few pages: an EKG, a consult letter. But you decide. You are their primary doctor, you know best.”

Mon: As we move to an electronic environment, what are the challenges we have with privacy, security and confidentiality that may be different than what we experience in the paper world?

Bowers: As we give clinicians timely access from their homes and offices, basically wherever they are, it has raised a lot of issues about who gets access and what measures we’ll put in place to limit that access. We developed what we call our physician portal, where security and the HIPAA regulations play a very big role. Our position is that there has to be a relationship to the patient or we will not give out full access. We make them go over some hurdles.

Berkowitz: We decided that one of the major benefits of this system was access. If I create a record, it is expected that any physician within Northwestern or in our hospital enterprise system can access it. We look at that as a huge benefit.

We allow access to all physicians, but not to every person in the hospital. In the hospital, nurses can only see records for patients on their floor. Only physicians have broad access to the records.

On the outpatient side, our staff and nurses needed to have broad access because we didn't know who was going to walk in the door next. But our staff also knows that audit trails can follow them and if they violate confidentiality they can lose their job.

Hanson: In a positive way and a collaborative way, HIM professionals within organizations can provide education on confidentiality and privacy to all levels of staff. The biggest threat, in my experience, has always been the "nosy neighbor." That is where people riding in an elevator or sitting in the cafeteria or walking down the hall are overheard discussing patients. This is much more common than compromises to the electronic health record. The vigilance needs to be part of an operating policy house-wide.

Henderson: And we need to realize, as well, that the electronic record has benefits when it comes to security and confidentiality. We talked about providing access to users, but we can also restrict it. And we have the audit trail. With a paper medical record, it is impossible to go back and see who's been reading it.

Hanson: When that paper record came back to your department, you never knew where it had been.

Henderson: And now we know exactly who has viewed it, what they have done to it, what time they did it.

Mon: As we move to electronic records and particularly personal health records, the consumer will have much more contact with their health information than ever before. What kind of education will consumers need as they assume responsibilities for managing their health information in the future, and where will they get it?

Berkowitz: Getting consumers to start managing some of their healthcare online is very appealing across the board and to physicians. But, we have to be careful about what we call the personal health record versus using clinical informational tools to support the general clinical workflow and disease management. Clinicians have years of training in interpreting medical data. Patients don't.

Henderson: In terms of educating patients to maintain and safeguard their personal health records, three minute public service announcements on television won't be sufficient. It will take a grassroots campaign to ensure consumers understand how to manage an online record and how to use the information available to improve knowledge of their health status. Security issues will need to be addressed to demonstrate methods of transmitting personal health information without compromising the security and integrity of the record.

Hospitals have a long history of educating patients on a variety of subjects. For instance, parenting courses come immediately to mind. I can see hospitals offering a one-hour course titled "Your Legal Medical Record." Education could be provided to community groups, civic groups, even the families of nursing home residents. And, HIM professionals are the most suitable instructors. We are the institutional keepers of the record and have knowledge of the content, use and storage of the information.

On Preparing to Play New Roles

Mon: As we move toward this electronic environment, are there skills for which we will have to educate and train our HIM professionals?

Sullivan: I think there would be some things that would enhance the role of the HIM professional. In general, the HIM professional should definitely have skills in informatics. I am not talking about the theoretical part of informatics, but rather a more hands-on type of program with some technology enhancement. Obvious technical skills regarding use of computers and possibly local area networks would help, which they may already have because medical records is a technology-driven department. Database management skills, skills in different software packages to pull data out of data repositories, knowledge of how to manipulate data, all would be helpful.

Henderson: The more we can learn about database management and reporting, about SQL, or structured query languages that get information out of databases.... We need to have that knowledge to enhance what we know on the HIM side, so we

can see the global picture.

Mon: As HIM professionals get more technical, how do you see them collaborating with IT professionals who are already very technical?

Henderson: We have a very robust automated workflow with our Horizon Patient Folder™ product. Because I know the technical side of that workflow and the SQLs, I know the stored procedures and what goes into them and understand the databases. I am able to work with IT to create efficient workflows, and know the end result we're looking for and how to communicate our needs in terms they understand. We work together to make our processes more efficient and our system more robust.

Sullivan: All we need to add to the curriculum is systems analysis. Because what you are able to do, Lynne, is have an understanding of multiple systems, the technical system environment as well as the clinical and HIM environment, which really is a system as well. So you are able to walk between those two and communicate. Between the two, you are the translator. HIM individuals can play that role. But the only way a translator plays the role is to know both languages.

Berkowitz: The two things that came to mind are system engineering and data vocabularies.

Sullivan: Additional education I would recommend is in communication and presentation skills.

Mon: If you could give a singular piece of practical advice to an HIM professional as they move into this electronic health record environment, what would that be?

Hanson: My practical advice would be to never say you are too busy or that your plate is too full. Embrace being that e-HIM or HIM champion for your organization and collaborate with others to make the transformation happen. Because no matter how full your plate, if you are working on a team and the values and goals are shared, it will all get done.

Berkowitz: Communicate. Make sure you have a very open line of communication to physicians and the IT side until you learn what everyone needs. And help to manage expectations, to make sure everyone has a sense of ownership, to understand all the problems.

I'll also throw out the old saying: "Don't let the perfect be the enemy of the good." There are ways to make an electronic system that is theoretically perfect from an HIM or medical record perspective, but you have to learn to balance quality with efficiency to get a system that everyone will use.

Congressional Testimony on EHRs

From the statement made by David Brailer, M.D., Ph.D., National Health Information Technology Coordinator, U.S. Department of Health and Human Services, in testimony he gave on June 17, 2004, to the Subcommittee on Health, House Ways and Means Committee.

"I thank you for inviting me here today to discuss the Administration's efforts to increase the use of information technology throughout the healthcare industry. As you know, this is a high priority for the President and Secretary Thompson. The priority has been further accelerated by the President's call to make electronic health records (EHRs) available to most Americans in the next 10 years and by the creation of my position to achieve this goal. Your thoughtful leadership and that of your subcommittee toward achieving this goal has been widely recognized and demonstrated through the e-prescribing and other health information technology (HIT) related provisions in Medicare Prescription Drug, Improvement and Modernization Act of 2003.

"...There is unprecedented enthusiasm and commitment for changing the day-to-day world of healthcare with HIT from leadership across sectors, and my goal in the next year is to focus this into a well-developed plan and a set of coordinated actions to accelerate the widespread adoption of EHR and e-prescribing.

"The Administration has already made significant progress in this area. Specifically,

- ...As part of the Federal Health Architecture, we adopted clinical terminology standards across federal agencies through the Consolidated Health Informatics (CHI) initiative. The Department of Health and Human Services (HHS), Department of Defense (DoD), Department of Veterans Affairs (VA), and other Executive Branch agencies have endorsed 20 sets of standards, such as standards for medications, labs, and immunizations. These standards will make it easier for information to be shared across agencies and could serve as a model for the private sector.
- The Secretary created the Council on the Application of Health Information Technology (CAHIT), which has been the coordinating and internal advisory body for HHS. CAHIT has served as the primary forum for identifying and evaluating activities and investments that promote and/or complement evolving private sector initiatives and strategies.

“The Executive Order of April 27th not only created my position within the new Office, but it also required the Departments and agencies of the Executive Branch of the federal government to work together to develop and align policies and programs that will achieve our common goal of using HIT to improve the safety, quality and efficiency of health care in every area of this country.

“...I will highlight the key initiatives that are critical to meeting our goal of making electronic health records available for all Americans. These initiatives fall into three categories: 1) automating clinical practice, 2) interconnecting care, and 3) improving population health.”

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