EHR Adoption in LTC and the HIM Value - Retired

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Electronic health record systems offer many opportunities for long-term care (LTC) facilities and their patients, and momentum is building for their widespread adoption across care settings.

Although some federal health IT initiatives benefit long-term care, LTC facilities are not eligible for direct financial assistance through the meaningful use incentive program. Without funding to offset their IT investments, LTC facilities must be all the more effective and efficient in their adoption of electronic systems and technology.

HIM professionals can lend LTC valuable support ranging from workflow analysis, EHR selection and implementation, and maintenance to system development. They can provide practical knowledge of:

- Legal, regulatory, and standard practices for medical records
- Documentation requirements for the medical record
- Data analysis and reporting
- Information flows both in the facility and between facilities
- Coding and reimbursement issues related to documentation
- Protocols and requirements in the security, exchange, and protection of health information
- Maintaining data integrity with routine compliance audits
- Record and information management and governance protocols

This practice brief outlines the factors driving EHR adoption in LTC facilities, how EHRs affect LTC facilities, and the value HIM professionals can bring to LTC facilities in the process of transitioning to EHRs.

Drivers for EHR Adoption

LTC facilities are adopting EHRs despite the lack of financial incentives provided to hospitals and physicians. Studies of EHR adoption among LTC facilities show LTCs are using EHRs at a similar rate as physician practices. Almost all LTC facilities use electronic systems to complete the Minimum Data Set (MDS) and have the ability to electronically transmit MDS data to federally required repositories. Twenty to 30 percent of LTC facilities have a partial or full electronic system.[1,2]

A number of drivers are compelling LTC facilities and communities to adopt EHRs, including:

- Changing consumer expectations
- Quality of care and patient safety
- Administrative efficiency and effectiveness
- New business models

Changing Consumer Expectations

LTC providers need to transition to EHRs to meet demands for consumer-centric care and transparency. Typical LTC patients are not technologically oriented, but their children and grandchildren are technology natives who use computers, smartphones and electronic media daily. These relatives are beginning to expect their interactions with LTC providers be prompt, convenient, and preferably online.

Transitioning to EHRs does require a culture change for LTC organizations. Currently, few LTC providers have established an infrastructure to allow residents and family online, electronic access and communication. When an LTC provider does implement an EHR, the vendor tends to promote the financial and clinical capabilities rather than patient access.

HIM professionals are uniquely positioned to be the link between providers, clinical staff, and patients regarding electronic health information and utilization of personal health record (PHR) data. Individual healthcare providers maintain only a part of a patient's health record, so bits and pieces of health information reside with multiple providers.[3] The burden for compiling a complete medical history, including nonprovider-directed care typically is on the LTC patient's family. LTC providers that integrate a PHR into their EHR network allow patients, families, and providers to be more involved in care and documentation.[4]

Impact on Patient Safety, Quality, and Availability of Care

Implementing an EHR in an LTC facility can improve the quality of care depending on the software system and how it is implemented, utilized, and nurtured. One of the most important drivers for LTC facilities adopting EHRs is the system's effect on quality and safety.

EHR systems can provide the following benefits for LTC providers:

Reduction in medication-related errors. Using an integrated pharmacy database to enter medications can provide alerts to allergies, drug interactions, and side effects. An interactive system can alert nurses to follow-up on results of *pro re nata* (PRN) medications. A bar-coding system can alert nurses if they administer the wrong medication. EHRs can also help ensure that medications are given at the right time.

In addition, many systems can be programmed to perform an audit at the end of the medication pass or shift to alert staff to any missed medications or treatments.

Improved clinical documentation and decision making. EHRs typically include charting templates with intuitive prompts to help ensure that staff review and chart all pertinent clinical information and are alerted to contraindications. EHRs with database functionality allow users to enter information in one part of the chart and direct that information to other sections for auto-documentation, such as the MDS. Some systems also have the capability to send an e-mail or phone alert to key individuals who need to be alerted when critical values or information is recorded.

Health information exchange. Transitioning care between healthcare providers, such as admission, discharge, or transfer to or from the hospital and emergency room, is a critical time for patients. Coordinating care requires timely communication of crucial information. Electronic health information exchange (HIE) between providers and through HIE organizations are facilitating the prompt sharing of information, which improves patient safety and quality of care.

Telehealth or telemedicine. Telehealth allows patients and clients to be treated and clinically monitored electronically (e.g., vital signs, weight, oxygen saturations). Telemedicine can link patients served in LTC facilities and communities to providers and specialists. Adopting EHRs linked with telehealth or telemedicine technology can present opportunities for HIM professionals to champion EHR accessibility, security, storage and retention, and retrieval and analysis of clinical data.

Administrative Efficiency and Effectiveness

EHRs can help LTC facilities achieve administrative efficiency and effectiveness, including:

Improved data analysis and audits. The EHR brings data together in one place, ensuring easy access to the most current information by all providers from various locations at any given time. Data are available, legible, and can be extracted into various reports, audits, and administrative alerts.

Because of this, LTC facilities can easily analyze and evaluate clinical trends (such as antibiotic usage or ordering of labs without documented symptoms) to support the organization's quality assurance and improvement initiatives. Many EHRs can be programmed to run specific audit checks on time frames specified by the facility. These audits can include documentation checks, integrity checks, and user access audits for HIPAA compliance.

Coding and links to billing. A clinical system that is fully integrated with the financial system will further streamline operations. Codes assigned by qualified HIM professionals can be pulled directly to the patient's bill for proper reimbursement.

Clinical documentation can also link directly to the billing operation (e.g., administration and charting of vaccines or use of certain wound supplies).

Linking this process with an effective data analysis and audit process helps ensure compliant billing.

Going green?storage expenses. Traditional paper charts in LTC facilities tend to be voluminous in nature. LTC facilities must ensure their records are properly stored and maintained based on federal and state law and regulations regarding record retention compliance. Whether on or off site, storage expenses and record management can be costly. EHRs do not eliminate the need for storage, but they have shifted the way records are archived, retained, produced, and destroyed.

Until the last decade, judicial decisions have outlined liability primarily around the failure to maintain proper records. However, there has also been legal action associated with the inability to locate records, including records kept beyond retention expiration dates, records destroyed before expiration dates were reached, or records displaying gaps or unexplained omissions.[5]

Emerging Business Models and Drivers

With the federal government incentivizing adoption of EHRs for physicians and hospitals, LTC facilities may find their business partners looking to maintain relationships with organizations that use technology to share information and coordinate care. LTC facilities may find their referral sources changing as hospitals and physicians create communication mechanisms built on technology.

Another driver emerging as a result of healthcare reform is the move toward accountable care organizations and bundled payments. Technology will be a factor in the success of these new delivery models, which will affect LTC facilities.

HIM's Value with EHR Implementations

LTC facilities and senior living communities are at various stages of EHR adoption. HIM professionals can offer leadership and support in the planning, implementation, and ongoing maintenance of EHRs and other health information technologies. While the EHR brings new variables to heath record management, the foundation of information management remains the same: health records and information must comply with regulations, accreditation, professional practice, and legal standards, and they must be complete, timely, accurate, readily accessible, and protected.

As with other healthcare sectors, LTC has been burdened with the false perception that an EHR eliminates the need for HIM services and functions. While the elimination of the paper record changes the HIM department and its functions, deploying and maintaining an EHR requires professionals with higher technical skills.

Healthcare organizations that have implemented EHRs have found that clerical roles and staff are eliminated and more educated, technically advanced staff are required to perform HIM functions. Early EHR adopters in LTC are also finding this to be the case.

Due to the complexities in maintaining and managing EHRs, HIM positions in LTC can no longer be staffed with untrained clerical staff or nursing assistants. In order to maintain quality health information systems, properly trained staff and allocation of resources for education and ongoing training are necessary.

Appendix A provides a comprehensive description of the HIM roles and functions in LTC.

New Roles for HIM with the EHR

HIM responsibilities are increasing as more LTC facilities adopt EHRs. Due to limited funds and resources, as well as the corporate structure, LTC facilities often lack on-site IT support services. Lack of on-site support increases user frustration and disrupts workflow processes, hampering the effectiveness of the EHR.

HIM professionals are taking on the following new tasks in LTC to provide user support and health IT management:

- Performing workflow analysis and redesign

- Coordinating system updates and downtime procedures
- Supporting users and providing on-site IT troubleshooting
- Managing system access and security
- Monitoring and continuously improving data quality and data integrity
- Planning, evaluating, and selecting new technology with a leadership team
- Leading and managing EHR implementations
- Optimizing, streamlining, and coordinating multisystem integration and interface for continuity of data across multiple systems within an organization
- Training staff on how to use the EHR
- Leading EHR governance processes, policies, procedures, and decision making
- Coordinating the electronic record management program

HIM services can support implementation and maintenance of the EHR by serving as the internal go-to person to support all users with issues related to timeliness, accuracy, retention, security, access, and data integrity. The HIM professional's skill set and the organization's complexity will dictate the exact nature of the new roles and functions. At a minimum HIM professionals must be part of the EHR implementation team and establish EHR governance and management processes.

Appendix B provides a useful vendor selection grid to support the evaluation and selection process. Stratis Health, the quality improvement organization in Minnesota, has developed a comprehensive health IT implementation toolkit available to LTC facilities at www.stratishealth.org/expertise/healthit/nursinghomes/nhtoolkit.html.

Changes in Traditional LTC HIM Functions with the EHR

Many of the qualities needed to manage the paper medical record are the same qualities required to manage the EHR. Attention to detail; ability to organize data and ensure data accuracy; data reporting; evaluating, understanding, and interpreting regulatory standards; and the many other skills that HIM professionals possess will be critical to maintaining an accurate and functional EHR.[6]

Some of the basic HIM functions may remain the same with the implementation of EHR; however, the process to complete the functions will change. As described below, traditional HIM functions will be redefined, leveraging the HIM skill set to facilitate the transition from a paper-based process to EHRs:[7]

Master resident index. HIM staff members can assist in researching how to positively identify patients at the time of registration and import photographs to reduce duplicate registrations. They can monitor assigned medical record numbers and amend source documents with the accurate number when applicable.

HIM professionals also can address index integrity issues such as duplicates, aliases, and proper identity processes for HIE activities.

Record assembly. In lieu of assembling the hard-copy chart, HIM staff will be redeployed to review EHR documentation, facilitate completion of outstanding data, monitor completion of data and records on admission (concurrently and discharge), and scan and index paper documents received from outside providers.

Auditing. While some auditing processes will be automated by internal flags such as unsigned reports, unreviewed lab, or special reports or missing reports, HIM staff will still assume responsibility for ensuring the information is tracked and completed. Notifications for completion may be sent electronically versus flagging a printed hard-copy document with a removable redi-tag. HIM staff can assist in auditing documentation to ensure the quality of the content that reflects delivery of services and supports reimbursement.

Moving from filing and thinning to document imaging. Filing paper records will be replaced with scanning and indexing documents. Imaging may become minimal as external documents become available electronically or exchanged automatically.

Auditing correct posting of documents within a resident's EHR, whether automatically or manually scanned, will need to continue. Quality monitoring processes will need to be implemented and procedures maintained for completion, retraction, rescanning, retention, and destruction.

Retention and destruction. Organizational policies for retention and destruction will need to be maintained for paper, hybrid, and electronic records. Data and record retention in EHR systems require HIM oversight. Destruction must occur in accordance with facility policy.

Release of information and disclosure management. Whether release of information occurs electronically or by hard copy, HIM professionals understand the applicable disclosure requirements. Responding to requests for records will require multimedia formats, including electronic exchange, electronic access, printing, and secure e-mail. Disclosure requests can come from patients, representatives, other healthcare providers, payers, auditors, regulators, attorneys, and others.

Managing the release of information program and adherence to organizational policy is critical for compliance and adherence to privacy requirements.

Coding. If EHR products incorporate encoder technology, computer-assisted coding could change coding to become more of an auditing function to ensure full capture of all codes. Without an encoder, traditional coding methods will be used and codes entered into the EHR system.

Forms management to screen and report design. Forms management, design, and approval will morph into a new process with the EHR. A process for designing, reviewing, and approving templates, data input screens, and EHR reports will replace the forms committee.

Transcription. Transcription may be reduced due to use of natural language processing (NLP), direct charting, and point-and-click charting by clinicians. NLP will shift transcriptionists to the role of NLP editor. HIM roles include training staff, system administration, template development, monitoring accuracy, and a new role for transcriptionists as document editors.

Increasing Importance of Privacy, Security, and Compliance

With the HITECH Act's expansion of HIPAA, the increased emphasis on privacy and security to support HIE, and the rollout of Medicare and Medicaid auditing programs, HIM professionals are assuming new leadership roles as the compliance, privacy, and/or security officer. As documentation and clinical record systems increase in complexity in response to the changes in the LTC environment, HIM professionals provide valuable expertise and assistance to maintain health information systems that affect the quality of care including regulatory, legal, compliance, and financial issues.[8]

Appendix C and Appendix D provide additional information on privacy and compliance roles, respectively.

Audit and Quality Monitoring within the EHR

Implementing an effective audit process is a challenge when moving to electronic records, but it is critically important in LTC. Regardless of the media in which health information is maintained, the content, completion, timeliness, and accuracy of documentation directly affect the quality of care, patient safety, organizational operation, compliance with standards of practice, reimbursement, survey compliance, and maintenance of a legally sound record.

At a minimum, records should be reviewed on admission and hospital return, concurrently on a monthly or quarterly basis, and upon discharge or death. Not all audit findings will be correctable. Information from those findings that cannot be corrected should be collected, tracked, and analyzed for training or retraining, system evaluation, and improvement.

Documentation within an EHR can be abstracted easily and reviewed based on individual user or discipline (e.g., a new employee or graduate of nursing), type of documentation per category charting (e.g., falls, skin, pain), or documentation within a specified time period (e.g., review all progress notes within the past 24 hours).

As portions of the record change from paper to electronic, policies and procedures will need to be updated related to documentation monitoring. HIM staff can assist facilities by implementing system edits within the EHR, which can save time for completing former manual auditing procedures.

For example, organizations can implement internal notifications, calendars, and assignments to remind staff members of their work plan for the shift when they sign on. Another example of an internal system edit is to notify the staff member at the time

of attempted log off of a missing signature on a med sheet, a progress note in draft format, or assessments that need to be locked. Logs and audit trails can be audited for tracking appropriateness of access based on a user's authorization.

HIM staff can take a proactive role with the quality improvement process to ensure the data collected are managed, analyzed, and reported at the quality assurance committee meetings. HIM professionals should analyze patterns of concern identified through audits, identify causation factors, evaluate the system, take measures to correct the problem, and monitor the system to determine compliance.

LTC facilities are or may be subject to a number of audits by outside agencies, including licensing and certification organizations, the Office of Inspector General (for corporate compliance and HIPAA privacy enforcement), Centers for Medicare and Medicaid Services (for HIPAA security enforcement), a fiscal intermediary or other insurer (medical review to support billing), or the facility's corporation for compliance. Preparation is key for a successful outcome to an external audit.

Knowing what documentation will be needed, where to get it, and how to present it to the surveyor or auditor is critical. HIM staff can manage a grid that includes the types of possible audits or surveys, a list of what supporting documentation will be required during the survey or audit, and a reference to the location of that documentation.

AHIMA's "LTC Health Information Practice and Documentation Guidelines" address monitoring guidelines that apply to paper, hybrid, and electronic systems.

Notes

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Appendixes

Four appendixes are included in the online version of this brief, available in the AHIMA Body of Knowledge at www.ahima.org:

- Appendix A: HIM's Role and Functions in LTC
- Appendix B: Vendor Questionnaire for EHR System Selection
- Appendix C: The HIM Professional as Privacy Officer in LTC
- Appendix D: The HIM Professional as Compliance Officer in LTC

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