

EHR Adoption in LTC and the HIM Value. Appendix A: HIM's Role and Functions in LTC

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HIM professionals working in LTC facilities using EHRs are responsible for the following areas and tasks:

Supervisory/Management

- Develop and maintain policy and procedures and job descriptions for the health information department
- Manage human resource functions for the department, including interviewing, hiring, staff scheduling, training, performance evaluations, disciplinary actions, and terminations
- Supervise health information staff to assure staff competency and performance
- Provide guidance, motivation, and support to health information staff
- Monitor department budget as directed
- If designated: may serve as the HIPAA Privacy Officer or Security Officer depending on expertise and facility need

Quality Monitoring and Quality Assurance

- Participate in the facility quality assurance committee and process
- Optional: Coordinate the facility quality assurance program
- Maintain a qualitative and quantitative audit/quality monitoring process
- Conduct and maintain routine audits including admissions/re-admission, concurrent/quarterly, MDS, diagnoses, acute problems, and discharge
- Conduct and maintain focus audits on problem areas, QA concerns, Quality Indicators, Quality Measures, and survey issues
- Collect and report data from audit findings to QA committee
- Develop an action plan for identified problems/concerns

Health Information Management Functions

- Maintain physical protection of health information to prevent loss, destruction and unauthorized use of protected health information (PHI) maintained in the EHR
- Assure security of PHI by assigning log in/passwords or other personal identifiers for authors' electronic signature
- Assign level of access for applications within the EHR based minimum necessary for each staff position and outside users such as business associates
- Manage the release of health information functions for the facility including review and processing of all requests for information according to facility policies and procedures that support HIPAA regulations
- Maintain a forms management system via design/revision of templates within EHR applications to enhance standardization for data entry that meets state, federal laws, streamline data entry at point of care (replaces designing hard copy forms). Function includes screen design and data field definition and print formats as well as development of standard online data collection procedures and data dictionary definitions
- Develop systems for retention of clinical records stored in an electronic format, purge clinical records from the system according to established record retention guidelines
- Complete facility statistical reports such as monthly facility statistics, daily census, and licensure reports as applicable
- Provide in-service education as applicable on health information issues
- Provide orientation to new employees on topics such as the purpose of the clinical, record completion, confidentiality, documentation standards and error correction procedures as it relates to maintaining the integrity of the clinical record within the EHR
- Provide orientation to new employees regarding facility specific HIPAA privacy and security safeguards

- Maintain the Care Plan and MDS schedule and transmit MDS information
- Review MDS validation reports and take appropriate actions to ensure errors are corrected
- Retrieve and analyze Quality Indicator/Quality Measure reports

Computerization/Automation

- Participate in decisions related to the electronic health record including systems selection, planning, and future expansion
- Serve as a resource for the initial and on-going training for both in-house and outside users on the use of clinical applications within the EHR
- Serve as internal user support for troubleshooting problems with data entry and/or retrieval of clinical information
- Facilitate contact with software or hardware vendor concerning issues with software and/or hardware
- Complete data entry functions to maintain updated resident specific information within the clinical information system
- Monitor security of the system such as assuring audit trails and password security are in place
- Monitor audit trails showing threads of activity occurring within the electronic system which can be used to investigate individual access patterns, either by user or for a particular file. and follow up with possible breaches in confidentiality/privacy/security per regulations
- Assure the software is updated with the annual addendum of International Classification of Diseases (ICD)
- Coordinate back up, down time and recovery processes. Develop a plan for worst-case scenarios when the EHR is unavailable; HIM staff should coordinate daily system disaster plan (e.g., printing of key documents, maintenance backup, paper systems, coordination of data entry or scanning of key data elements after unplanned down times). Provide ready access to necessary forms to revert to paper processes. Facilitate staff training/support during EHR down time.
- Attend software user group meetings and/or network with healthcare providers using the same software to optimize system applications
- Install software upgrades when applicable

Data and Records Management Functions

- Maintain master resident index and census register via data entry process
- Initiate admission/discharge auditing processes, contact Physician or disciplines as appropriate to complete information, request information from external sources based on rules, regulations. Requests for information may be in the form of telephone, fax or electronic notification
- Complete coding and indexing of admission/discharge diagnoses, code diagnoses at regularly scheduled intervals and update concurrently throughout resident's stay
- Scan all incoming clinical information from outside sources on a daily basis
- Track return of signed telephone and faxed orders, scan within the EHR
- Schedule and monitor the timeliness of physician visits to assure compliance with Federal and State regulations

Reprinted from AHIMA's "Long Term Care HIM Practice and Documentation Guidelines." Available online at www.ahima.org/resources/infocenter/ltc/guidelines.aspx.

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