Forms Management Process: Keeping Pace with EHR Development

by Kathy J. Westhafer, RHIA, CHPS

Have you given any thought to how your medical record committee and forms management process need to transition with electronic health record (EHR) development? At the Christiana Care Health System, we have. Here's our evolving story.

Christiana Care is a two-hospital health system located in Wilmington, DE. In addition to the acute care facilities, the system includes a number of physician office practices, a home health agency, and a transitional care facility. Computerized records have been minimally used within the organization for more than 10 years, with increased use and deployment over the past five (though records remain primarily paper-based). Systems in use today include a clinical data repository (used on a limited basis and currently transitioning to an EHR), a document-imaging system, and an electronic record system for many of the physician offices.

For years the medical record committee focused on documentation within the acute care paper record. In addition, the forms management committee (a subcommittee) focused on review and development of paper record forms. Changes began approximately four years ago when the medical record committee, through HIM leadership, assumed systemwide responsibility for the record review function and became the System Medical Record Committee (SMRC).

Transitioning to an e-HIM World

Throughout the journey toward the EHR, SMRC's role and responsibilities have been continually evaluated. A key transformation point occurred with implementation of a new pharmacy system, a new surgical scheduling system, and a replacement for the legacy order entry system, with "go-lives" scheduled within several months of each other. The vision was that the data repository would become an active system for documentation—thus an EHR. The first data elements entered were patient's height, weight, and allergies. This would be followed by development of electronic forms for initial medical and surgical nursing assessments and special care nursery forms.

As development of electronic documentation tools began, initial discussions centered on functionality for documenting clinicians. Interestingly, as the mechanics of forms approval were discussed, it became apparent that although processes were adequate to handle the paper medical record and the record within the document-imaging system, requirements for electronic documentation were lacking. The first step was to establish an electronic forms review process. The group developing the process and performing the review became known as the Functional Documentation Committee (FDC). When the FDC hit a few roadblocks, an ad-hoc group, conceptually functioning like an EHR council, was established for determining electronic documentation requirements. The guiding principle of this group is to transition existing paper-based requirements appropriately to the electronic world. While the ad-hoc group does not meet regularly, its membership is maintained and can be called into action when needed.

The FDC is comprised of several members who also serve on the forms management committee (e.g., nursing, legal, HIM). Members include staff from information services (IS), who perform the forms development function; nursing; and performance improvement. Support of this committee is a collaborative effort between HIM and IS. Lacking tried and true methods on how to handle this new concept, the team experimented to find a method that was both efficient and effective and produced a usable tool that would ensure newly developed or modified electronic forms would withstand the "legal health record test."

Electronic Forms Review

The resulting process calls for review of an electronic form at three phases: conceptual review, build review, and final review. The clinical sponsor of the form is required to be present for each review phase. Conceptual review is generally done prior to

form development and is used to determine form value. A standard format was developed to provide structure and consistency for the sponsor and committee during this stage.

Throughout form building, data elements are reviewed for definition consistency to the existing application. In the build review phase, the form and its functionality are reviewed online in a nonproduction environment. If possible, a printed version of the form is made available for review. At this point, the committee has an opportunity to ask questions and recommend changes in areas such as format, functionality, and process. A final review occurs after recommended changes are applied and issues resolved; this serves as one last check prior to form production and use.

If during redesign of documentation processes the need for downtime forms is determined to be important to operations in the electronic environment, that form is reviewed along with the electronic version. The streamlining benefit of review in this setting affects both the form sponsor and the committees. Through understanding of the downtime process, disposition of the downtime form is also determined (e.g., backload and destroy, retain in the paper chart). Approval of downtime forms is communicated back to the forms management committee for tracking purposes.

The diverging processes of the forms management committee and the FDC dovetail with both groups reporting on activities through the SMRC. Escalation of issues, though rare, can also be dealt with through the SMRC. Changes to existing forms may be requested no more than quarterly and require the same review process, albeit greatly simplified. Special consideration is given to form changes that would affect quality of care and patient safety.

It's an ongoing process. Christiana Care staff immersed in the transition to the EHR continue to be proactive in evaluating, suggesting, and experimenting with best practices surrounding the development and maintenance of the health record. Currently under discussion are how to combine the forms management committee and the FDC, thus blending the approval processes of paper forms and electronic forms, incorporating audits for documentation compliance per form into ongoing record review, and creating a similar review and approval process for ambulatory EHR documentation. Close scrutiny continues for documentation improvement for the documenter and the caregiver team by minimizing double documentation and designing views that allow the clinician to find important information at a glance.

New Form Conceptual Review Sheet

Every form presented to the functional documentation committee will be considered part of the legal medical record unless proven otherwise.

Project/Form Name: Date:

Analyst/Programmer: Sponsor:

Item		Description	Accepted/ Follow-Up
1.	What is the intent of the form(s) and what need is being addressed?		
2.	How is the information being collected or stored today? (Not required for the initial conceptual review)		
3.	What are the benefits of using a form?		
4.	What are the major types of information to be included on the form?		
5.	Who will view, create, modify, and unchart the information? Any user that can create a form should have the privilege to modify and unchart (unless there is justification for why the users should not be able to perform these functions).		
6.	Will this form require a new position or role?		
7.	Will the data charted on the form display on the flowsheet? If yes, what will be displayed on the flowsheet? Why?		
8.	Will any rules be required? If other departments will be notified, what will other departments receive (e.g., printed notification, report, task list item)? What will the process be for the receiving departments?		

9.	Will the information integrate with any other system components? Will any of the information be defaulted from or to other forms or parts of the system (e.g., orders)?		
10.	What workflow changes will be required?		
11.	Is this considered not part of the legal chart? Why? Is the information on this form documented anywhere else in the chart?		
12.	Printing should be kept to a minimum. Who will print? What departments need to print? Will printing need to be automatic or will users print manually? Will the form be printed when needed or routinely? What kind of printing will be needed (e.g., forms printing, chart server, custom CCL report)? Consult HIM about printing needs for all forms.		
13.	Are there plans to develop reports that are pulling data from this form?		
14.	Is an electronic signature required? Will signing the form be considered the electronic signature?		
15.	If replacing an existing form (online or paper), has the form been reviewed and updated?		
16.	Anticipated live date:		
17.	Anticipated support needed for go-live and post-go-live? Who will support the form?		
18.	What audit process will be used once the form is live?		
19.	Issues:		
20.	Other:		
Conceptual Approval Date:			

Christiana Care Health System uses this worksheet to adapt paper forms to electronic documentation.

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