Strategic Importance of Electronic Health Records Management: Checklist for Transition to the EHR

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This checklist assists in the transition from paper to an electronic health record (EHR) as a legal medical record. Whether paper or electronic, the system must meet certain standards to be considered a legal business record. This checklist will help your organization with the preparation for going paperless and ensure that when you do, you can get rid of the paper.

Once the decision to move to an EHR system is made, organizations must address the change in culture for going paperless. If an organization embraces technology fully, this may be an easy task. If an organization has deeply embedded traditions, this task may be quite arduous. However, if organizations do not fully embrace the change, the migration to an EHR system will be destined to fail.

The decision to go paperless involves having enough confidence in the electronic system to let go of the paper system. This which includes ensuring that the system handles amendments, corrections, authentication, backups, down time, confidentiality, and printouts and reports for disclosure purposes.

Getting Started

- Form an executive-level committee (ELC) to review and approve the change to a fully electronic system. Obtain executive-level support that will review and approve the migration.
- Form an organizational-level committee, empowered by the ELC, management, and all members of the organization to establish and implement policies and procedures required to manage the change to a paperless system from start to finish.
- Review and revise your legal health record policy. This should be a comprehensive policy that describes each step involved in the transition. This may mean planning for a hybrid environment (both paper and electronic).
- Develop a comprehensive plan of actions and milestones that details each step involved in the move to a fully electronic system. This plan should contain a definitive date for the completion of the migration and should detail individual departmental or divisional rollout dates.

    - Consider the following when setting the date and defining the process: Is it for all patients seen after a certain date? For all documents created after a certain date? For all patients discharged or admitted by a certain date? Will you transition all areas of the organization at once or individually? Will you transition by unit or by document type (e.g., lab then radiology then transcription)?
    - Develop a comprehensive data map of all organizational workflows and processes that may be affected by the transition to an electronic system. This data map should address both administrative and clinical workflows.
    - After an organizational review of these data maps, consider appropriate steps to re-engineer and redevelop workflows as appropriate.
    - Develop comprehensive processes and procedures that address the conversion of paper-based documents to an electronic form.
    - Develop a communications plan that provides the organization with a clear understanding of the change process involved in moving toward a fully electronic system. The plan should address the responsibilities of all individuals within the organization (clinical and nonclinical staff). Education and information tasks should be incorporated into the plan. Consider the use of letters, posters, fliers, e-mail, or presentations with a clear message of the change.

- During the transition, consider developing a grid or matrix that describes where and how to find specific document types (e.g., history and physical exam forms, operative reports, discharge summaries, physician orders, test results). Review

the practice brief "The Complete Medical Record in a Hybrid EHR Environment," available in the FORE Library: HIM Body of Knowledge at www.ahima.org.

Research

- Research state regulations (e.g., defining the electronic record, retention of records, electronic signatures).
- Research applicable accreditation standards:
  - Joint Commission on Accreditation of Healthcare Organizations standards (e.g., Standard IM.2.20 addresses data integrity, IM.2.30 addresses continuity and disaster recovery for both hard copy and electronic records)
  - Commission on Accreditation of Rehabilitation Facilities
- Research federal laws (e.g., HIPAA and the Privacy Act of 1974 if they apply to your organization).
- Review the Federal Rule of Evidence, Article VIII. The EHR should meet the federal and state rules of evidence to stand as a legal business record. Review the practice brief "Maintaining a Legally Sound Health Record," also available at www.ahima.org, for a summary of the rules of evidence.
- Research applicable FDA regulations:
  - 21 CFR 11: Electronic Record and Electronic Signatures Regulation
  - FDA Guidance for Industry-Computerized Systems Used in Clinical Trials
  - 45 CFR 46: Protection of Human Subjects
- If appropriate to your facility, review the applicable federal conditions of participation (e.g., defining the electronic record, retention of records, electronic signatures).
  - 42 CFR 2: Conditions of Participation for Drug, Alcohol, and Substance Abuse
  - 42 CFR 418: Conditions of Participation for Hospices
  - 42 CFR 482: Conditions of Participation for Hospitals
  - 42 CFR 483: Conditions of Participation for Long Term Care Facilities
  - 42 CFR 484: Conditions of Participation for Home Health Agencies
  - 42 CFR 485: Conditions of Participation for Rehab
- Seek out professional peers who may be working through this same issue in your local community, as well as your state and national communities. Join different AHIMA Communities of Practice (e.g., E-HIM™, Enterprise Imaging, HIPAA: Computer-based Patient Record).

Content Issues

- Consider the following issues related to content:
  - Can patient information be efficiently and legibly accessed and retrieved?
  - Does documentation indicate the exact date and time of the recording of the event and the name of the documenter? Is this information viewable? Printable?
  - How will versioning of the electronic record process work? How will the original unaltered version and edits be maintained? How can you tell whether the report has been edited?
  - How long after an entry has been made can the documentation be corrected or amended? Amendment rules should be similar to those in the paper world. The change, date and time, and author of the change should be viewable and printable.
  - The rule for correcting data and reports should be the same for paper and electronic systems. Evidence of the correction with the date and time and author of the change should be viewable and printable.
  - If a patient requests an amendment or correction, how will it happen in the EHR system? Will the information be scanned or imported as a text file into the record?
  - How will you know the record is finalized or completed on the system? Paper or paperless, record completion business processes will still be needed. How will temporary documentation (e.g., preliminary findings, draft reports, unsigned and authorized reports) be clearly identified?

- What is the data validity and completion process?
- Will physicians complete records online? How will they know to do that? Will you give them a break on suspensions during the learning curve and still be in compliance with the Joint Commission?
- Will the EHR system allow electronic signatures that meet state and federal law? Is the signature viewable? Printable?
- Will the EHR system allow required cosignatures (e.g., students, residents, nurse practitioners)? Is the signature viewable? Printable?
- How will documentation reviews be performed (e.g., medical record reviews)?
- Have individuals who do data abstraction, utilization review, or auditing been trained to identify where to find information?

Format Issues

- Consider the following issues regarding format:

  - Consider before and after formats comparing the paper document to the computer-generated documentation. Is there a comparable electronic version of each document?
  - Will you realign roles and responsibilities for existing committees (e.g., will the forms committee approve the format of the electronic record)?
  - How should the record be organized?
  - Is the information in the record organized for efficient retrieval of needed data? Is it readable?
  - Can the record be brought to paper in a readable format?
  - Are there customizable views for different groups of users (e.g., clinical view, HIM view, audit view)?
  - If alerts and reminders are part of a legal medical record, are they viewable? Printable?
  - Plan for auditor access to the record online without the ability to see or search for other patient records an auditor is not privileged to view. How will the auditor be trained to use the system?
  - How will staff be trained to read through the online record to find information?
  - If copies need to be printed out of the system, ask if the system can label printed reports to include a prominent watermark or label with information about disposing of the copy or print the report on colored paper.
  - How will you integrate paper from outside the facility? Will it be scanned immediately or kept in a temporary paper folder for a period of time?

Policy and Procedures

- Consider the following issues related to policy and procedures:

  - Do organizational policies need revision in response to issues identified with going paperless?
  - Address retention for electronic records. It is critical to verify how long documents or data is readily available from various systems. Does the electronic data go away after a couple of years? How long will data be kept online? After archived, how will it be retrieved?
  - If a record must be thinned, how will you go about it? How will this information be retrieved?
  - What is the downtime (manual backup system) policy and procedure? Will documents completed while the system is down be part of the legal medical record? Will they be scanned into the record?
  - Will printing be restricted? Unrestricted printing means you are not paperless. (For a discussion on the pros and cons of printing, see the practice brief “The Complete Medical Record in a Hybrid EHR Environment. Part III: Authorship of and Printing the Health Record.”)
  - Determine where copies may be printed in the organization and methods to be used for copy disposal. Will there be an audit trail to identify users who have printed reports from the system?

Confidentiality

- Consider the following confidentiality issues:

  - Will patients have online access to their medical records? If not, you will have to print the record for their review.

- How will the release of information function be completed? Can the record be attached to an e-mail, faxed, stored on a CD, or printed? Review HIPAA requirements.
- Is the system HIPAA compliant?
- Should nurses and other caregivers be restricted to viewing only the patients on the unit where they are assigned?
- What about physician access to records when they are not recorded as a treating physician (e.g., consultants, referring physicians, physicians doing committee reviews, researchers)? Can any physician on staff have access to any patient record?

Hardware

- Define your hardware platform. Are you using a high-availability platform or a stand-alone platform? Is there a redundant or mirror database or system server?
- Define the backup process, including media, retention, and rotation cycle. Test it.
- Define the disaster recovery process and the acceptable downtime. (There will be system maintenance windows or system upgrades.)
- Is there enough hardware available for access? Plan for access points across the facility for physicians, nurses, all caregivers, and nonclinical reviewers.
- Consider budgetary issues for your department (e.g., additional printers, supplies, personal computers).

Interfaces

- Plan for interfaces (e.g., lab, ADT, radiology). How often is information transferred to other systems? What is the reconciliation process?
- Is there an interface for the master patient index to the EHR system so that medical record numbers merged in the index will be automatically merged in the EHR system? Or will staff have to go in and out of different systems to keep the medical record numbers accurate?

Lessons Learned

As the saying goes, “experience is the best teacher.” Here are some lessons learned by other HIM professionals as they have made the transition from a paper-based to an EHR:

- Take the time to visualize the workflow of all HIM functions supporting a paperless health record. You will experience a number of “a-ha!” moments. This is critical to the planning phase. To be successful, it will be necessary to map the transition from paper to paperless by carefully considering all the changes that may or will occur. Encourage your staff to assist you in this visualization process. Continuously asking “what if?” will allow you to discover many of the important issues during the planning stage.
- During the planning stage, identify what clinical data will be needed for any population reports. Be sure this data is being discretely populated in the EHR. Often, the report desired cannot be generated because the data wasn’t captured, stored, or retained for that purpose. There are many instances where the HIM department or other departments maintained logs of patients; each of these logs should be able to be created and maintained as part of the population reports.
- It will be equally important for other members of the implementation team to visualize the changes in their workflow. HIM professionals can provide invaluable insight for the clinical team in assisting it to consider all issues affecting the clinical workflow and going paperless.
- If the record is moved from the active database to an archival database, check that all of the record is retrievable in the same format and doesn’t require special programming to retrieve or print the record.
- Be actively involved in testing the backup. Don’t wait until the system has crashed and needs to be restored to find out that the backup doesn’t work adequately.
- When implementing a new electronic record system, don’t forget to have the project plan include the printing of all reports. Some systems are sold as paperless and do not have reports developed to be printed out of the system if necessary.

- When a new data element is created in the system, make sure that the new information is viewable and printable. Some systems take additional programming to get the new data into a viewable or printable format.
- If you are going paperless in several different systems (e.g., radiology, physician order entry), evaluate hardware needs in each department to ensure that all staff can access the system as appropriate to their job functions. Some systems have licensing limitations and could cause access restrictions.
- Ensure that system updates occur on the server and do not require manual intervention on each computer or desktop. Imagine having to visit every computer or user each time a change is made. Likewise, verify that one installation grants application access to all profiles on that computer.

References

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For additional resources, seek out professional peers working through the same issues. Review the e-HIM practice briefs and search the FORE Library: HIM Body of Knowledge. Join AHIMA Communities of Practice such as e-HIM, Enterprise Imaging, and Computer-based Patient Records.

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