Electronic Health Record Adoption in Long Term Care (2014 update)

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This practice brief supersedes the January 2011 "EHR Adoption in LTC and the HIM Value" practice brief.

Electronic health record (EHR) systems offer care, treatment, and communication opportunities for long-term care (LTC) facilities and their patients and residents. Momentum is building for the widespread adoption of EHRs across long term care settings, which will enhance the ability of these facilities to exchange health information. This practice brief outlines the factors driving EHR adoption in LTC facilities, and how EHRs affect LTC facilities.

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

Health information management (HIM) professionals credentialed through AHIMA have the skill set to provide valuable support to LTC facilities, including workflow analysis, EHR selection, training, implementation, maintenance, and system development as well as support for increased use of EHR clinical information for quality assurance and performance improvement. HIM professionals also bring to the table practical knowledge of:

- Legal, regulatory, and standard practices for medical records
- Privacy expertise for system requirements regarding accounting of disclosures and patient rights
- System build and setup for proper and efficient documentation
- Documentation requirements for the medical record
- Data analysis and reporting
- The flow of Information both within and between facilities
- Coding accuracy and reimbursement compliance as it relates to documentation and quality of care assessment
- Protocols and requirements in the security, exchange, and protection of health information
- Maintaining data integrity with routine compliance and quality audits
- Record and information management and governance protocols

Drivers for EHR Adoption

LTC facilities are adopting EHRs despite the lack of financial incentives provided to hospitals and physicians. Almost all LTC facilities use electronic systems to complete the Minimum Data Set (MDS) and have the ability to transmit MDS data to federally required repositories.[1,2]

A number of drivers are compelling LTC facilities and care 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 to other providers involved in the patients'/residents' care. Transitioning to EHRs does require a culture change for LTC organizations. Currently, few LTC providers and LTC EHR vendors have established an infrastructure to allow residents and family an online patient portal or other means of electronic access to their health record.

Individual healthcare providers maintain only a part of a patient's health record, so portions of health information may reside with multiple providers.[3] The burden for compiling a complete medical history, including non-provider-directed care, is typically on the LTC patient's/resident's family. Thus, these caregivers need EHR access that enables them to manage the care of the resident/patient. LTC providers that integrate patient portals into their EHR network allow patients/residents, 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 a LTC facility can improve the quality of care depending on the software system, its set-up, implementation, use, and maintenance. For example, EHR systems with built-in auditing, monitoring, alerts, or other triggers that guide staff to risks and areas needing compliance or re-evaluation promote opportunities to improve patient 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, side effects, and Part D drug billing information as applicable. 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 may provide clinical guidance alert to risks and give options. 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 as clinically indicated, such as the Resident Assessment Instrument (RAI)/Minimum Data Set (MDS).

Health information exchange. Coordinating care requires timely communication of crucial health information. Transitioning care between healthcare providers—at admission, discharge, or transfer to or from the hospital and emergency room—is a critical time for patients/residents. Some states have developed a "universal" transfer paper/electronic form which provides specific data agreed upon by a variety of provider types as essential data for patient/resident care in order to meet the need for continuity of care through consistent, complete, appropriate information during the transition between healthcare providers.

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. Concurrently, the skilled nursing facility may be the nursing link for HIE and increased focus will be initially more evident through the increased ease and speed of referrals to the acute hospital and other providers.

Administrative Efficiency and Effectiveness

EHRs are a valuable asset to assist LTC facilities with:

- Improved data analysis and audits
- Coding and links to billing
- Going green/storage expenses
- Record retention and proper safeguarding

New Business Models

With the federal government incentivizing adoption of EHRs by physicians and hospitals, LTC facilities may find their business partners looking to maintain relationships with organizations that use technology to share health information and coordinate care.[5] LTC facilities may also find their referral sources changing as hospitals and physicians create communication mechanisms built on technology. Part of the expansion of the meaningful use criteria fosters this communication between all providers by requiring the recipients in the program to show evidence of interfacing with other providers.

Another driver emerging as a result of healthcare reform is the move toward value-based purchasing and bundled payments. Technology will be a factor in the success of these new delivery models.

Appendix A of this practice brief provides a comprehensive description of the HIM value and functions in LTC.

Considerations for implementation of EHRs in LTC

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. Responsibility to lead the management and auditing of the EHR includes, but is not limited to, clinical documentation and reports, retrieval management, monitoring and auditing, and maintaining compliance with regulations. Following is a list of considerations for EHR implementation.

Pre Implementation

- Performing workflow analysis and redesign
- Facilitating compliance with regulatory, and legal aspects of the EHR (including HIPAA) during system development
- Assisting in facilitating EHR compliance with the HIPAA requirements for residents and family and/or responsible party access to the EHR
- Planning for coordinating system updates and downtime procedures
- Planning, evaluating, and selecting new technology with a leadership team
- Leading and managing EHR implementations and post evaluation
- Coordinating multisystem integration and interface for continuity of data across multiple departments within an organization to ensure efficiency and optimization of systems (i.e., integrating laboratory and pharmacy to create physician order sets, thereby ensuring accuracy and completion)
- Training staff on EHR functionality including data input and reporting
- Leading EHR governance processes through the development of policies and procedures as well in decision making

Implementation

- Supporting users and providing on-site IT troubleshooting
- Managing system access and role-based security
- Monitoring and continuously improving data quality and data integrity
- Optimizing, streamlining, and coordinating multisystem integration and interface for continuity of data across multiple systems within an organization
- Ongoing training of staff on how to use the EHR, including data entry, documentation evaluation, and reporting functions
- Coordinating the electronic record management program
- Supporting EHR adoption by providing problem solving skills and training to the clinical staff

Post Implementation

- Supporting users and providing on-site IT troubleshooting
- Managing system access and security
- Monitoring and continuously improving data quality and data integrity
- Coordinating the electronic record management program
- Ongoing staff training to address system changes or upgrades, or areas in need of improvement

Appendix B of this practice brief provides a useful vendor selection grid to support the evaluation and selection process.

Changes in LTC Health Information Management Functions as a result of the EHR

Some of the basic HIM functions may remain the same with the implementation of EHR. However, the processes to complete the functions will change.

Master resident index. There is still a need to positively identify patients at the time of registration, manage duplicate registrations, and monitor assigned medical record numbers, as well as amend source documents with the accurate number when applicable.

Record assembly. In lieu of assembling the hard-copy chart, staff will be redeployed to review EHR documentation, facilitate completion of outstanding data, monitor completion of data and records on admission (concurrently and upon 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 labs, or special reports or missing reports, staff will still assume responsibility for ensuring the information is tracked and completed. Auditing is a particularly important function due to increased scrutiny from external monitoring agencies and payers.

Moving from filing and thinning to document imaging. Filing paper records will be replaced with scanning and indexing documents. Imaging will 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 management and oversight. Destruction must occur in accordance with facility policy and state regulations. Automated destruction systems must be monitored to ensure accuracy and appropriateness if used.

Release of information and disclosure management. Responding to requests for records will require multimedia formats, including electronic exchange, electronic access, printing, CD, flash drives, thumb drives, or e-mail as the resident/responsible party requests. Disclosure requests can come from patients/residents, representatives, other healthcare providers, payers, auditors, regulators, attorneys and others.

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

Coding. If encoder technology is incorporated into LTC EHR systems, computer-assisted coding could lead to coding becoming more of an auditing function to ensure full capture of all codes. Although this is seen primarily in the acute care system, there is the potential that such a tool could be developed and incorporated into an EHR system utilized in LTC. When the staff member enters the diagnostic information, the software generates a selection of code options from which to choose in order to most accurately and completely reflect the resident's condition.

Without an encoder, traditional coding methods will be used to enter diagnosis codes into the EHR. This is the case in the majority of EHRs found in LTC organizations. It is important that code assignment is consistent and accurate based on information within the health record. Codes are used on the UB-04 and MDS 3.0.

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 approval process.

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, leadership roles such as the compliance, privacy, and/or security officer will become vital.

Appendix C and Appendix D [from the 2011 version of this practice brief] provide additional information on privacy and compliance roles, respectively.

Audit and Quality Monitoring within the EHR

Implementing an effective audit process to ensure the integrity of the system is a challenge when moving to electronic records, but it is critically important for LTC facilities. 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/resident safety, organizational operation, compliance with standards of practice, reimbursement, survey compliance, and maintenance of a legally compliant 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, retraining, system evaluation, and improvement. For example, blanks left in the medication record or, treatment records should be identified in the documentation through the traditional late entry process. Typically, you cannot go back and add initials on a MAR or TAR that was not originally entered to state that the medication or treatment was administered. Documentation should be reviewed for any patterns that require education or retraining.

For those systems which utilize speech recognition software as the method of introducing clinical observations, it is even more important that a review of the documentation be conducted to ensure the system is accurately "hearing" the "dictation" of the provider.

Documentation within an EHR can be abstracted easily and reviewed based on individual user or discipline (i.e., a new employee or graduate of nursing), type of documentation per category charting (i.e., falls, skin, pain), or documentation within a specified time period (i.e., 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 to reflect documentation monitoring and management.

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.

A proactive approach to the quality improvement process should be taken to ensure the data collected are managed, analyzed, and reported at the quality assurance committee meetings. Health information management 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), the 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 and proactive management are key to 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. This information would be used in educating clinical staff in the documentation process to reflect the care provided.

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

Notes

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Appendices

Appendix A: HIM Role and Functions in LTC

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 ensure 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, Security Officer, or Compliance Officer depending on expertise and facility need

Quality Monitoring and Quality Assurance Performance Improvement (QAPI)[1]

- Participate in the facility quality assurance performance improvement committee and process
- Optional: Coordinate the facility quality assurance performance improvement 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
    - Complete, monitor and report the hospital re-admission rate statistical information timely to assist with identifying potential areas of improving hospital re-admissions
- Conduct and maintain focus audits on problem areas, QAPI concerns, Quality Indicators, Quality Measures, and survey issues
- Collect and report data from audit findings to QAPI 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
- Ensure 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 a 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 and 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 RAI/ MDS schedule and transmit RAI/MDS information
- Review RAI/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."

Note

1. CMS. Quality Assurance & Performance Improvement (QAPI). http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/nhqapi.html.

Appendix B: Vendor Questionnaire for EHR System Selection

Evaluation Criteria	Vendor A	Vendor B	Vendor C
Name and Address of Home Office			
Phone Number			
Sales/Contact Representative			
Date of On-site or Web Demonstration: Date of Sample Facility Visit:			

Cost			
What is the cost (dollar amount) to purchase the system?			
What is the cost of the annual support license fee?			
What does this fee cover?			
What are the training costs?			
Are there travel expenses?			
What is the cost (dollar amount) for technician service PRN?			
What is the cost (dollar amount) for program/report development requested by facility?			
Are there any additional fees?			
What are the hardware requirements? Interface capabilities? Scanned documents, voice recognition, connecting disparate systems (HL7) Possibilities for developing other programs within the EHR program/database? I.e.: Human Resources, Mandatory education tracking, attendance, Master schedule program, policy and procedure repository and access portal? Can the facility utilize the program as a modifiable database?			
Background Information			
In what states does the company have clients?			
How many nursing homes use the system?			
How many nursing homes purchased the system each year?			
How long has the company been in business?			
How long has the company been in the nursing home business?			

Determine stability of the company: Has the company ever been bought out? Who owns the company?			
Is the company debt free?			
How did the company start out? What was its primary focus (i.e., pharmacy, hospital with LTC as side business, etc)?			
How does the company make its money (i.e., sale of software, pharmacy business, resale of data back to facility, etc.)?			
Is it proprietary?			
How many staff members does the company employ (programming and support)?			
Has the number of staff increased as more facilities are brought onto the system?			
Start-up Support			
What are the steps involved in launching the program?			
Are on-site trainers provided?			
What experience and type of support are provided in the start-up?			
Is support for back data entry at the start of the Go Live available?			
Continuing Support			
What type of support is available on a 24-hour basis?			
How is support provided (i.e., phone, online)?			
What is the turnaround time for response?			
What is the cost of support?			

What does support cover?			
What are the qualifications of the support personnel (i.e., programmers, nurses, CPAs, etc.)?			
How is the software updated?			
How frequently is the software updated?			
What is the required downtime for software updates?			
How are updates received and installed?			
Are there opportunities for continued training? If so, how?			
Program Information			
Does the system operate on a Windows platform? Is it web-based or installed on servers in the facility? How are specific modules incorporated? (Pharmacy, ICD-9 codes, Rehab schedule and charting) Do they interfaced with the MDS? Can you generate customized facility specific reports (e.g. auditing) and what is the process?			
What is the programming language?			
What type of database is utilized?			
Does the system require additional proprietary software? If so, what is the cost and support for this software?			
Does the company guarantee that its software will provide for a totally electronic (paperless) operation?			
How long has this capability in software been available?			
Does the system provide bar code input and read capability?			

Is the system's touch-screen technology compatible?			
Does the system support or will it support in the e-signature capability			
Can information be entered from remote devices?			
Does the system allow the facility the ability to customize the PDA screens?			
Does the system come equipped with standardized form templates? (ex. care Plans, Assessments) If so, are they customizable by the facility, or is a request submitted to the software company programmers?			
Interoperability and Standards			
How has the company incorporated the HL7 LTC EHR-S Functional Profile standards?			
What are the company's plans or roadmap to add EHR functions over time?			
What are company's plans for CCHIT EHR product certification?			
Are HL7 interfacing/messaging standards utilized?			
Does the company allow information to be imported to a database? If so, how is this done and to which modules? *(List the company's references of nursing homes that are currently utilizing this function.)*			
Does the company allow information to be exported? How is this done? *(List examples of import/export functions currently up and running.)*			
Does this include capability to upload digital files and pictures? What format (PDF)?			
Does this include capability to scan in reports? What format?			
Does the clinical program interface with the financial program? How do the programs interface (i.e., demographic, clinical to bill, census)?			

Will the clinical/financial program interface with the pharmacy company's software program? How? What is the cost?			
Will clinical/financial program interface with contract therapy company software? How? What is the cost?			
Modules (Programs) Available			
Clinical Module Components			
MDS/CAAS			
Does the MDS input screen look like the MDS? Is it user friendly?			
Is the care plan standardized or can it be individualized and personalized (i.e. automatically adding patient's name to goals and interventions)?			
Does the system include daily charting of all disciplines?			
Does the system include triggered charting? (i.e.: Admission assessment is begun by one nurse but not completed, system triggers next nurse of what components are not done.)			
Does the system include nursing assistant (ADL) charting? Are the screens user-friendly? Are they available on touchscreen technology? Can specific pictures or videos be imported into the system for reference by the CNAs? (i.e.: picture of a splint properly applied to a specific resident, or a video of how to transfer a specific resident, etc.)			
Does the system include a pharmacy database? How does it interface with the EHR? How is this maintained and updated? How does it interface with the pharmacy company?			
Does the system include physician order entry system with alerts and warnings?			
Does the system include safety features for med pass? Does it include audit functions and alerts for missed meds or required PRN med documentation? Does the system automatically scroll the nurse to charting screens when certain document is required? (i.e.: PRN med documentation, respiratory minutes, behavior charting, side effects of psychoactive meds)			

How are medications passed/accounted for? Does the system offer key/touch or bar-coded entry?			
Does the system include automatic stop orders? When adding orders into the system, can automatic care plans be generated? (i.e.: adding an order for an antibiotic triggers the automatic creation of an antibiotic care plan)			
Does the system include a documenting screen online and/or the ability to print MARs? Can the MAR's be printed in the 30-Day Grid format as is the paper version?			
Are there any additional costs for CPOE and E-MAR?			
Does the system include a rehabilitation module? Notes, schedule prompts and time tracker? How does this compare to a stand-alone rehabilitation software programs? Does it communicate with the financial module to populate rehabilitation minutes and diagnosis to the UB04? Does it interface and populate the MDS?			
Does the system include a scheduling Program (for consults, labs, etc.)?			
How easy is the system to use for coding? Does it print out in ICD language or can it be modified into normal medical terminology?			
How and when are updates provided? Is the update adversely impacted by facility modifications to the medical terms?			
Are there any additional costs for ICD updates?			
Does the system include a quality assurance/assessment module?			
Does the system include a financial program?			
Does the system include an inventory program?			
Does the system include a human resources program?			
Does the system include a staff schedule program			

What is the process for access to Resident information during system downtime?			
Does the system offer education and CEU tracking capabilities?			
Ease of Use			
What do the documenting screens look like? Are they easy to maneuver?			
What is the method of entry (mouse, keyboard, touch screen, voice, bar code)?			
Does the system use programmed notes or narrative entries?			
Does the system include an electronic co-signature capability?			
Are data entered via electronic forms with drop-down boxes? Or selected from columns similar to a spreadsheet?			
Is decision prompting available?			
Are electronic alerts and contraindication notifications available? Are these pre-programmed, or can the facility add its' own?			
What is the average time required to teach the system to staff?			
Are there pre-existing forms/ templates in the system that are customizable or does the facility have to supply all template designs?			
How would a facility handle charting from agency staff for the first time? How easy is the system to use for agency nurses who have had little to no exposure to the software?			
Can the facility develop its own reports, or is this assigned to a company technician?			
Can the facility revise its own documenting screens, or is this assigned to a company technician?			
MDS			

Does the MDS input screen look like the MDS?			
Does the system provide the ability to automatically scroll between sections of the MDS?			
Does the system allow for the printing of historical MDS files?			
Are errors triggered at data entry or at the end in an error report?			
Can internal checks be added to the system, or is this pre-programmed?			
Is there an MDS assessment scheduler? How does this work?			
When opening a new MDS, do the previous scores pull forward or is the new assessment blank? Can the facility decide this factor? How do these features display? Can staff identify which are previous scores and which are current?			
Does information from the care plan transfer into department-specific assessments?			
Can the RUG score be checked at any time during entry?			
Can the CAAS be linked to the Care Plans when completing that section of the MDS?			
Does the system indicate the best reference date based on supporting documentation? Does it have RUG forecaster capabilities?			
Are the MDS screens coded to identify questions/sections that impact reimbursement or the quality measures? (ex. Green = reimbursement impact)			
Does the system pre-populate the MDS from the existing EHR documentation (ex. ADL's) What percentage is pre-populated?			
What type of file format is used to create the MDS submission batches (ex. flat file)? What billing systems is it compatible with?			
Preadmission Questions			

Does the system allow information to be input for a pre-admit prospective resident and then deleted from the system if not admitted?			
Does the system allow the facility to custom design the entire pre-admission questionnaire online? How many fields?			
Does the pre-admission module transfer information directly into the MDS as desired by the facility?			
Reports			
Does the program print the 802 rosters and 672 census reports? How are these reports updated? Can information be manually updated by staff?			
Does the system have tickler file capability to handle outpatient and consultant schedules?			
Does the system produce the CMI Census Roster Report for analysis and submission?			
Can reports be customized based on all fields of the MDS, triggers, CAAS, RUGs, care plan, census, and assessments?			
Does the system produce QIS Survey reports? (ex. New Admits last 30 days and alpha census)			
Can the facility design its own reports or must this be done by software programmers?			
What formats are available for report export? (csv, pdf, excel)			
Does the system have existing trending reports and alerts? (i.e. weight change, decline in ADL)			
Are the CMS QM Indicator reports available to staff in the system and are they updated with each MDS batch submission?			
Security			
What are the security features of the system?			

Does it provide security rights by password? Does it have a biometric capability?			
Can the facility determine the parameters of password and changes?			
What type of integrity audits is available? Can these be specified by the facility or are they pre-programmed?			
What type of edit functions is available?			
Can notes be appended without disturbing the date sequence (i.e., physician countersignatures)?			
How is an entry error corrected? Is the procedure for making error corrections the same for all documentation in the EHR?			
How does the system accommodate surveyors during regulatory inspections where log-on and access to the EHR is requested?			
Can the facility easily create groups that limit access to only specified residents or resident populations? (i.e. Only a particular HMO)			
HIPPA/HITECH			
Does the system have the ability to lock records or portions of records that have been reproduced and released for a PHI request?			
Does the system have the ability to define the legal medical record and have a print all function for those specific documents? Does the print functionality allow the user to check off only certain documents or a specified time frame for printing?			
Does the system have the functionality to allow a user to create PHI/Restriction pop-up alerts in the system?			
Does the system have the ability to track accounting of disclosures?			
Does the system allow the user to mark certain documentation “confidential when entering it? (i.e. HIV status)			
Reference Checks			

Will the company supply a complete list of facilities serviced?			
List the name, address, phone number, and contact of the facilities contacted.			

Appendix C: The HIM Professional as Privacy Officer in Long Term Care

In the early 1900s the American College of Surgeons' Hospital Standardization Program provided guidance on how to organize data in medical records for research. Currently many disciplines use medical records for a variety of purposes. Since the early days, HIM professionals have guarded the integrity of the medical record through ethical and administrative guidelines.

The federal government built on these health information standards when it recognized the need to further improve the efficiency and effectiveness of healthcare systems by standardizing the electronic exchange of administrative and financial data. These changes are incorporated in HIPAA, the first comprehensive federal health privacy protection legislation. When combined with stricter state privacy protections, access to the medical record is surrounded by lengthy and complicated rules intended to safeguard medical information and protect the privacy of the individual. Employers looking for a privacy officer are looking for an individual familiar with applying HIPAA privacy regulations and health information standards of practice.

LTC organizations are covered entities under HIPAA and the expansion of HIPAA under the HITECH Act. The privacy rule portion of the HIPAA regulation mandates all covered entities appoint a privacy officer to enforce HIPAA compliance by the organization's officers and employees.

Many of HIPAA's privacy protection provisions evolved from medical record department practices. For this reason, HIM personnel are called upon to provide education and training in adopting HIPAA rules into organizational practices. HIM has been a source of information and ideas on the best way to protect health information. Many facilities already assign HIPAA enforcement to members of the HIM department.

Like the compliance officer, the organization's workforce must be trained and motivated to carry out the mandates of complicated federal and state regulations. The privacy officer in an LTC environment recognizes that regulations that apply to hospitals may need to be modified for their HIM department.

If a state has stricter guidelines than the federal regulations, the stricter guidelines must be followed. For example, federal provisions in HIPAA outline how to access records, but these regulations may be modified by stricter state legislation or other related federal regulations, allowing complete access to information in a shorter period of time such as the Medicare and Medicaid rules of participation. Federal and state regulations must be combined to provide the most protection for personal health information.

The privacy officer will be called upon to assist facilities in assessing current and future legislative changes in code sets, computer technology, and privacy practices as the government transitions the healthcare community to EHRs. President George W. Bush called for every individual in the United States to have an EHR by 2014. In 2004, President Bush signed legislation requiring the Department of Health and Human Services (HHS) to help advance efforts to achieve the goal for most Americans to have access to secure electronic health records by 2014. The Obama administration subsequently signed into law two major pieces of legislation designed to further these goals: (1) the Health Information Technology for Economic and Clinical Health Act (HITECH) within the larger American Recovery and Reinvestment Act of 2009 (ARRA) and (2) the Patient Protection and Affordable Care Act (PPACA), signed in 2010. The ability to collect quality data and protect data the confidentiality as it follows the person through the healthcare continuum is a key principle of HIPAA Privacy. The HIM professional is familiar with current regulations and can assist with the performance of risk assessments to evaluate compliance with the regulations as they relate to paper records for HIPAA Privacy and electronic records as they relate to HIPAA Security. Failure to develop a risk assessment and implementation plan places an organization at risk for data breaches with increasing penalties in terms of dollars and reputational damage. Civil and criminal fines and possible imprisonment are also now able to be levied on the individual responsible for a data breach.

The required content of the medical record has not changed because the storage medium has changed. The medical record standards that organized and protected the integrity of the medical record over the years are now under scrutiny from many

auditing branches of the state and federal government.

As the migration to EHRs continues to progress, the federal government is intensifying mandates for privacy protection. The federal HITECH Act, part of the American Recovery and Reinvestment Act, includes provisions to fund health IT and protect data to allow the public to feel more comfortable using EHRs and have their information follow them through the care continuum using information exchanges. HIM professionals understand the current health information environment. If the public is not confident that their sensitive information is protected, the e-HIM transformation faces a large obstacle.

Using health information training and methodology, the privacy officer is in a position to safeguard protected health information and smooth the transition to EHRs. The HIM credential is evidence of a working knowledge of health information practices. The current level of complexity of protected health information data management and exchange in the long term post-acute care is constantly increasing as is the demand on the skill level of health information managers, HIPAA Privacy and Security officers. AHIMA offers a specialized certificate of Certified in Healthcare Privacy and Security (CHPS) many employers rely on the specialized skills inherent in the HIM credential alone.

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