IHS EHR Business Process Recommendations

Below is a list of recommendations that have been found useful by other sites when implementing EHR. Please note that not all recommendations may apply to your site.

GENERAL EHR

- Use an implementation team approach to provide buy-in to the process, help partner people in resolving common issues, set timelines, and move the process forward. It is highly recommended that at least one member of Administration who has the authority to make decisions regarding staffing, purchasing, etc. be included on the EHR implementation team. This team should not disband after implementation but continue to work together resolving new problems, issues, or processes until all clinics are successfully using the EHR. Utilization of the IHS EHR Website (www.ehr.ihs.gov) and the EHR Web Board are vital to the implementation process.

- Define, document, and conduct drills on a back-up system and process when RPMS is down or electricity is off to capture the clinical information and orders in a manual format. The contingency plan should include a defined process to immediately enter as much information as possible into the RPMS system once power is restored. This will assist the facility and clinic to regain a real time medical record in the shortest period of time possible.

- Make maximum use of TIU templates for documenting clinical information, as opposed to free-form text entry. In general, the templates should be simple, need to include only the relevant information related to the visit and should be completed in a relatively short period of time. It is suggested that templates be designed for the major clinics and re-evaluated after 2-3 months of usage. A template subcommittee of the Medical Record Review Committee is the appropriate group to provide direction and approval for template development.

- All sites are encouraged to bring all clinics and services (PT, Lab, x-ray, pharmacy, etc.) up on EHR as soon as feasibly possible. The addition of another clinic should not be similar to the prolonged process often experienced with PCC+. Utilizing manual and electronic systems together becomes very cumbersome to the facility. EHR is a means to foster more automation, and manual processes will often delay productivity.

- Develop a TIU template for documentation of telephone calls, and chart reviews.

- If at all possible, hire temporary employees to assist with Super Users daily functions at times when the Super Users will be concentrating on EHR activities (e.g. during EHR setup and Super User training). This may also come in handy when the Super Users are spending their time training other staff.

- Sites should purchase privacy screens for monitors to assist with HIPAA compliance.

- There are several courses offered for different aspects of EHR—descriptions of these courses can be found on the EHR website. It is also possible to schedule conference calls and/or online meetings with the National EHR Program for basic overviews of the EHR.

- Expand performance improvement, risk management, and patient safety activites in the EHR environment.

- Policies and procedures that should be developed, reviewed and/or revised for EHR:
  - HIPAA
  - Standing orders for nursing, pharmacy, and lab
  - Lab orders from outside physicians
  - Over The Counter (OTC) drugs
  - New staff orientation policy
  - Health Information Management policies and procedures
  - Procedures for obtaining electronic patient signature on directives, pain contracts, and informed consents which are currently not EHR functionality.
  - A policy for correction of entries in the EHR needs to be a collaborative effort between providers, HIM, and IT staff.

PROVIDERS

- If the facility elects to have providers select ICD-9, E&M, CPT, and HCPCS codes, initial and ongoing coding training will greatly improve provider skills, speed, and accuracy of code selection.

- The more time spent in carefully and thoughtfully developing provider and clinic specific ICD-9 and CPT pick lists, the more useful these lists will be in improving accuracy of coding; this will in turn improve the accuracy of billing claims and the completeness of charge capture for services provided.

- Similarly, a concerted effort to clean up problem lists, including accurate coding of chronic problems, will make these lists much more useful to providers in selecting pre-coded Purpose of Visit diagnoses and codes. Data Entry staff can assist providers and work together in keeping the problem list updated and accurate.

- Consider providing inexpensive commercial typing instruction software for those users who have limited keyboarding and computer skills. Offering incentives and time for providers to improve these skills will pay off in speed and accuracy of documentation.

- It should be recognized that providers have different styles of collecting information and documenting encounters. Some will document during the patient visit, while others will take notes and complete their documentation after the encounter. Both are valid, but the latter introduces delays of information access by other providers, pharmacists and is a risk management issue. With the input and cooperation of the medical staff and other affected departments, facilities will establish and enforce policies that define when EHR encounter documentation is complete. The practice of writing notes at the end of the day, or on a separate day, is discouraged.

- Medical record reviews for timeliness, accurateness and completeness should be continued in the EHR environment, as in the paper environment.

- Part of the required setup for EHR is the explicit definition of policy or standing orders. Many facilities are lax about defining, documenting, and updating their standing orders; EHR will reveal clearly and quickly when an organization has failed to do this.

- Providers, nurses, and other users need to be thoroughly trained on selecting the correct patient record and the correct visit context in EHR, to reduce the risk of erroneous entries and to ensure that results and notifications are sent to the appropriate providers.

HEALTH INFORMATION MANAGEMENT (HIM)

- Re-organize and re-focus the day-to-day processes of the HIM staff. The EHR process will significantly impact the existing activities of HIM; however, other functions need to be defined and become more dominant with the EHR. Examples of new and existing services for HIM include:

    - Continue to perform but also enhance the quality assurance review process of medical records. This includes assuring compliance with all the medical record documentation in the patient's record such as signatures, orders placed and filled, co-signature of orders, documentation of notes, and other similar review processes. In addition, HIM needs to conduct random sample reviews of medical records to assure compliance.

    - Develop a process for printing excerpts of the EHR to send to referral and specialty physicians.

    - Continue to follow the HIPAA Policies and Procedures on the use and disclosure of patient health information.

    - Maintain an error log of deficiencies and develop a process for informing and instructing the provider to complete any deficiencies.

    - Determine how non-electronic medical record documents will be handled, filed, and made available to providers. These will include outside documents such as discharge summaries and consult reports, as well as internal documents such as consent forms, signature forms, documents produced by diagnostic equipment such as EKGs and other charts and flow sheets.
        - At some point an EHR-compatible imaging application will be available to view scanned documents, but until then certain components of the record will continue to be on paper.

MEDICAL RECORD

- Once a scanning/imaging application is available, providers will need to identify if there are items in the patient's paper record that should be scanned in. Examples include key consultations and summaries, diagnostic and pathology reports, and so forth.

- Set an agreed upon reasonable timeframe to discontinue the use of the paper medical record and PCC+ forms during the clinical visit.

- Once routine pulling of the chart for patient encounters is discontinued, policies should be revised to specify any special circumstances in which the paper chart should be pulled.

- Discourage the use of paper notes for communicating among staff. The EHR allows the use of chat functions and notifications for such communications. Staff should understand that chat dialogues and notifications do not remain part of the permanent record; however, patient-related medical communications that need to be part of the record should be documented in TIU notes. The facility should develop policies restricting use of EHR for personal or administrative communications that are NOT part of the record.

- Eliminate the need and reliance on PCC and PCC+ Encounter Forms for documenting ancillary services (lab, x-ray and pharmacy) when using the EHR. Staff in ancillary departments needs to be trained on the use of EHR for responding to electronic orders and documenting their patient encounters. For ancillary ONLY visits, remember to document that the ordering provider is the primary provider and the secondary provider is the ancillary staff performing the tests for billing purposes. A valid reason or diagnosis for the test and the medical necessity should be documented.

CODING, DATA ENTRY AND BILLING

- Eliminate coding, data entry, and billing backlogs **PRIOR** to implementing EHR. There are several reasons to support this recommendation. First of all, the greatest benefit and value of an EHR to the providers, lab, x-ray and pharmacy is its real time review and reporting capabilities. If data entry or coding is backlogged, the medical record will not provide a clear and accurate up-to-date clinical picture of the patient. Second, as staff is becoming acquainted to the process of using the EHR in lieu of a paper medical record, they need to concentrate their efforts on the new process versus trying to manage a backlog and implementing a new process at the same time. Finally, if backlogs are not eliminated, they will tend to increase over time.

- As a facility gains experience with EHR, demand on Data Entry staff will be reduced. However, the need for Data Entry expertise will continue until the entire facility is using EHR for all clinical transactions and data recording. Even beyond this point, contingency planning will require the ability to manually abstract and enter data into RPMS following system downtime events. Overall, implementation of EHR should provide opportunities for Data Entry staff to move into coding positions or medical record reviews, Error Report research and resolution, scanning, and various data management functions.

- Coders should review each visit in the EHR for completeness of coding, error correction, and to ensure all provider and ancillary staff documentation requirements are met prior to billing the visit.

- The EHR doesn't change the requirement that managers of the ancillary departments work one-on-one with the business office staff in updating the RPMS packages to assure that all CPT codes are current and updated annually. In addition, the charge master in the RPMS billing package needs to reflect any increase or decrease in charges based on new and revised CPT codes.

- Monitor the PCC Error Report daily. With the implementation of the EHR, provider coding errors and certain other issues will result in an increase in the volume of the Error Report. To maintain accurate records in the system, to reduce the Error Report volume, and to move these visits through the billing cycle, dedicated staff should be assigned to

review EHR-related errors and resolve them in a timely manner. Education and communication is paramount to ensure that providers and departments are not continually repeating a process that result on the PCC Error Report.

- Coding of an EHR encounter will still require communication between the coder and the provider:
  - If a provider chooses to select all codes and after review by the coder there is a discrepancy, the coder will use the coding template in the EHR to query the provider.
  - If a provider chooses not to code, the provider will document the purpose of visit and select the .9999 code. The coder has the right and responsibility to interpret the documentation and code appropriately. The coder may send a notification to the provider for educational purposes aforementioned.
  - The provider is responsible for selecting the appropriate Evaluation and Management (E&M) Code.

- Consider dividing the Point of Sale error report into those functions related to pharmacy (e.g., the drug is not listed on the formulary, or return to stock process, for this insurance) versus those functions related to the business office (e.g., patient not covered under this insurance). Each area should respectively be given the rejections or errors to research and resolve. This process will divide more evenly the associated work to the departments who are responsible for those activities. In addition, since Point of Sale provides electronic billing and quicker reimbursement than manual processes, the errors and rejections from Point of Sale should immediately be researched and corrections re-billed to assure timely payments.

- Increase the number of Point of Sale contracts with insurers as soon as feasibly possible to eliminate the manual billing procedure of pharmacy claims.

- The Business Office staff needs access to the EHR to review the encounter prior to submitting the claim.

- Coordination between the biller and the coder is essential to ensure coding changes are entered in the RPMS PCC package, reflecting a true capture of all codes billed.

REGISTRATION / APPOINTMENTS / PATIENT FLOW

- Register all patients whether for a clinic visit or for other-than-clinic-visit, such as lab, x-ray or pharmacy only visits. These measures will ensure that all patients are registered and checked into the RPMS system regardless of their reason for visiting the clinic on that particular day.

- Use the PIMS scheduling application to its fullest capability in all locations. Facilities and departments should eliminate all reliance on paper-based appointment books and reminders.

- Run the Patient Registration Error Report at least weekly and correct all errors.

EMERGENCY ROOM

- Implement the EHR in the Emergency Room immediately after the clinics are operating effectively.

- Train providers, including contractors, to use the EHR and to document all the services provided.

- All EHR users should be trained in the full functionality of order entry, triage and ordering drugs and supplies.

PHARMACY

- The pharmacy should consider changing its workflow to accommodate pharmacy review of EHR orders and notes instead of hard copy review. Pharmacists should be able to use EHR in order to review patient records, and to document pharmacy encounters and patient education. A champion should be identified in the pharmacy to help foster the change from the reliance on the manual medical record to the electronic version. This may be a very difficult transition in that pharmacists have always utilized and relied upon a hard copy medical record.

- Maximize the use of Pharmacy Quick Orders for as many medications as possible. This makes the ordering process much faster for providers and reduces the chance of errors during ordering.

LAB / RADIOLOGY

- Document the reason or diagnosis for the lab or x-ray test either in the clinical template or in the lab or x-ray package. If any of these components are missing, the lab test should not be performed based on CLIA rules and regulations. Deciding how this process will work in the EHR needs to be discussed among providers, business office, nursing, medical records, and the lab and x-ray departments.

- Eliminate the need for manual copies of lab or x-ray orders; instead rely upon the information in the EHR.

- Eliminate paper lab logs; the lab package can provide a log of when the patient entered the lab, who ordered the lab test, when the test was performed, and when the result was posted.