# Health Information Management Staff Transformation Toolkit

A PRACTICAL GUIDE FOR TRANSITIONING STAFF TO THE ELECTRONIC HEALTH RECORD



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# FOREWORD

Federal and state laws are constantly changing the healthcare landscape, including the use of technology. Industry initiatives such as the Health Information Technology for Economic and Clinical Health Act (HITECH) and health information exchange (HIE) have expedited the move to implement electronic health records (EHR) across the nation. The design and operations of the traditional health information management (HIM) department is rapidly changing in this new environment. HIM professionals will be tasked with new responsibilities that require clinical leadership, management skills, and information technology (IT) knowledge. HIM roles will continue to evolve as full implementation is reached, and opportunities await HIM professionals who evaluate and upgrade their expertise to keep pace with changing practice.

HIM professionals will be required to identify skills and functions, work process improvements, and redefine information management practices in order to ensure the integrity and accuracy the health record in the electronic environment. They will work at the convergence of people, processes, regulations, organizational structure, standards, and system design. Given this magnitude of upheaval, change management, and expectation management will be critical to the successful creation of the emerging digital HIM department.

This toolkit is designed to support and guide HIM professionals. It outlines how information management will change and how HIM professionals and their departments can prepare for this transformation. Transformation gap analysis, skills assessment, functions assessment and other training tools will assist the staff transformation in the HIM Department.

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# **INTRODUCTION**

A health record is considered to be the business and legal record for the healthcare organization. Therefore, it must be maintained in a manner that complies with electronic health record (EHR) legal standards. In order to thoughtfully and appropriately manage the EHR, health information management (HIM) Departments must have staff with appropriate skills necessary for the organization to fully transition to the EHR. This is especially important since EHR software implementation will change operational processes and workflow practices within a healthcare setting. HIM departments must have the tools to assess staff and to ensure they are ready to transition to the EHR.

The HIM professional has an integral role to play in ensuring accuracy and integrity of the health record within the organization. It is imperative for HIM professionals to take leadership roles and collaborate with organizational staff to ensure that by listening, educating, and collaborating throughout the EHR transition sound information management principles are embedded in the health record.

### BACKGROUND

Over the years, there have been numerous publications and initiatives to facilitate the move of health information from the paper health record to an EHR. The Institute of Medicine has published multiple reports on the capabilities of EHRs and the impact on patient quality and safety. In 2004 President Bush issued an executive order to establish the Office of the National Coordinator (ONC) and to enable every American to have access to an EHR within 10 years. In 2009, President Obama signed the American Recovery and Reinvestment Act (ARRA) into law which had EHR incentives for providers and organizations to rapidly implement EHRs.

### **EHR INCENTIVES**

For many years, the Health Information and Management Systems Society (HIMSS) has used the EMR Adoption Model Trends (SM) to gauge the penetration of EHR implementation within the U.S. As a result of organizations progressing through the stages, there is a higher degree of clinical automation. With meaningful use measures rapidly driving adoption and implementation of EHRs in organizations across the country, this model has become the benchmark by which healthcare organizations measure the degree to which they are achieving meaningful use. HIMSS' intent was to provide an eight-stage framework to better understand the transition from a paper record to a fully functional electronic health record system. The model now suggests what it will take for organizations to reach the meaningful use measures based on the stages . According to the HIMSS US EMR Adoption Model(SM) for the 3rd quarter of 2011, a majority of hospitals—46%—have achieved Stage 3. Making the leap to Stage 4 seems to have many organizations stymied because of the complexity of implementing computerized provider order entry (CPOE).

# **LEADERSHIP**

A framework provides structure and a set of processes that support success at work. Given the complex nature of working in the healthcare industry, especially during a time where healthcare reform is expanding, leadership has become every HIM professional's responsibility. An HIM leadership framework is just as necessary for individuals in the trenches as it is for those in the boardroom.

Today's HIM leaders require leadership skills to help their organizations integrate health IT. Setting the stage for the transformation of HIM comes before the implementation of the electronic health record. HIM leadership must be preparing staff for the inevitable change in responsibilities both imminent and long term. It is necessary to communicate these anticipated changes well before implementation begins to set the expectation of what the future will bring. The focus should be on the need for all employees to grow in their skill set. Discussion about lifelong learning is a key component to the transition.



Discussing the changes in both the abstract and the concrete helps to set expectations. HIM professionals should remind staff that their existing skills, such as attention to data integrity, quality of medical record documentation, and problem solving skills, are transferable from paper to electronic environments. The focus should be on the need for all employees to grow in their skill set. Discussion about lifelong learning is a key component to the transition. Staff may continue their education through courses offered by the American Health Information Management Association (AHIMA). Encouraging staff to become AHIMA-certified professionals will position them as leaders and role models in the health information management community as well as technically skilled individuals who are poised to take on the functions created by EHRs.

The discussion will need to include information relevant to how the organization will support tuition reimbursement and competency examinations. If the organization's tuition support is not ideal, partnering with executive staff and the human resources department to develop a transition model is an option to explore. Losing

employees often has a negative impact on organizations. HIM professionals can build skills of existing staff through training and education, thereby retaining valuable staff while meeting the challenges of an evolving technical environment.

### VISIONING

HIM professionals should begin assessing their departmental needs for transitioning to the EHR through visioning activities. A good visioning approach will help HIM professionals think about the future and prepare them for the EHR transition. The visioning process should include research, evaluating common situations that staff encounter and how the workflow may change in the electronic environment. AHIMA has a Core Model for the HIM Future that addresses changing practice roles and functions. The first step in accomplishing this is to define the current state of the department, including analyzing all critical processes.

Developing an EHR vision statement for the HIM department in conjunction with the organizational goals will identify staff expectations for achieving a successful transition to the EHR.

### SAMPLE EHR VISION STATEMENT

The HIM department vision for the EHR is to provide excellent customer service and expert leadership in

- » Training on the use of the EHR
- » EHR standardization initiatives
- » Maintaining a structured format of the EHR
- » Actively participating in the input and output of the EHR
- » Educating and upholding documentation standards, principles, and regulatory requirements

The next step is to define the desired future state. HIM professionals should begin the visioning process by reviewing other organizations' transformations, engaging in discussions with colleagues, researching articles, and determining how others transformed their departments. HIM professionals should set up visits to other organizations that have transitioned to fully electronic processes. Once the current and future states are defined, the HIM director should compare and contrast them and create a road map that will prepare staff to utilize the EHR.

Visioning a future state should begin now. Proper preparation for a change takes a minimum of six months and includes assessing the gaps between the current work-flows and future workflows, identifying what new functions will be added, and determining how to plan the transition from a paper to an electronic environment. It will be critical to ensure that all workflows and the downstream effects of those workflows are considered and that they function effectively. Even after the organi-

A good visioning approach will help HIM professionals think about the future and prepare them for the EHR transition.

zation makes the leap to a hybrid or electronic record, the HIM department's vision for its future state requires continuous fine tuning for continued readiness as the organization's use of the EHR evolves.

### **FUTURE MODELING**

Once the visioning and a roadmap have been developed, determining the function and skills of staff will need to begin. The first step in this process is to engage the HIM management team, executive staff and Human Resources representatives in an exercise for future modeling of HIM services compared to current state. Begin with the vision of what functions will be transformed and what functions will be new to the department. Assess the volume of work and determine the expected number of full time equivalents (FTEs) to complete the function.

Part of the analysis is to determine what types of positions will be necessary to meet The most difficult part of the demands of the EHR. One of the most obvious for most HIM departments is the transition from filing paper records, to monitoring interfaced documents. Skills needed for this new role include attention to detail, ability to compare data in the EHR to data from the source system (quality control), and understanding the format of the electronic records. As the organization moves to capturing data directly into an EHR, more analytical skills become necessary, such as navigating through data displayed in a structured, tabular format to locate all relevant information to accurately assign codes to the patient encounter.

### **GROUND WORK**

The next phase is to determine skills and job requirements necessary for new positions. This work needs to be coordinated both with Human Resources and IT. IT may have ideas on what new functions HIM may be more gualified to perform. Examples of this include security access control, monitoring interfaces, or monitoring daily status reports. Once the new functions are determined, again the exercise for visioning may be applied to obtain an estimation of the number of FTEs needed.

A timeline for implementation is developed that includes sharing the transformation plans with HIM staff, posting positions, interview dates, and selection of new team members. The most difficult part of the implementation is the communication with staff. Generally HIM departments decrease clerical staff and create new positions for technical and analytical functions. The process for selection and preliminary information on layoffs is shared.

The most important part of this transformation is the fair consideration of all staff for all new roles. Identifying the interview questions and answers in advance is key. Other contributing factors to success in the new role include items such as skill set, education or certification, and prior performance review history. Once interviews are completed and the other elements of job success are scored, current staff may be assigned to new functions based on the evaluations.

the implementation is the communication with staff.

# **EVOLUTION**

Ensuring the accuracy and integrity of the record is crucial. The HIM staff must be evaluated to determine what skills are needed as the record migrates to electronic form. Our stewardship obligations are not new, but they are becoming more complex.



HIM functions that will be changed include, but are not limited to

- » Analysis
- » Abstracting
- » Assembly
- » Filing
- » Coding
- » Documentation improvement
- » Forms design and management
- » Chart completion
- » Master Patient Index (MPI) maintenance
- » Release of information
- » Third party audits
- » Interface management
- » Transcription
- » Data quality

To support this transformation, HIM professionals will require new skills as well as training opportunities to continually upgrade their skills. They must be comfortable with changing technology and able to adapt to a changing environment as systems are upgraded, replaced, and optimized.

### **JOB DESCRIPTIONS**

New job descriptions will be needed. It is important to reflect the current state as well as expand on future roles. As an organization implements an EHR and moves through the stages, a review of job descriptions will be necessary. While the core competencies may be developed globally, job-specific responsibilities also need to be included to ensure continuity. The core competencies include but are not limited to

- » Education
- » Experience
- » Medical terminology
- » Analytical skills
- » Problem solving
- » Attention to detail
- » Computer skills
- » Knowledge of health record content
- » Regulatory standards
- » English language and foreign language
- » Keyboarding
- » Customer service and communication skills
- » Specialized skill sets
- » Certification and credentials
- » Coding
- » Hospital and EHR systems

In conjunction with job description development, compensation rates need to be formally reviewed and adjusted as necessary. With the required upgraded skill sets and knowledge, increased education, and certification required to perform the functions in the EHR, the implementation of HIM positions should result in an overall increase in salaries. Appendix A is a Sample HIM Job qualification grid with explanations that may be used to help determine compensation rates based on competency, knowledge, skills, and advanced education and certification required for each level. With the required upgraded skill sets and knowledge, increased education, and certification required to perform the functions in the EHR, the implementation of HIM positions should result in an overall increase in salaries.

### **STAFF ASSESSMENT**

Determining staff preparedness is essential. Commercially available online assessment tools may be used for staff to assess current skills and identify gaps. The survey assessment should, at a minimum, include the following areas

- » Computer knowledge
- » Problem solving
- » Data comparison and attention to detail
- » Microsoft Office skills
- » Internet usage



In addition to the commercial product, a gap analysis tool may be developed for the department. There are core skill sets that cross all functions that may be assessed. This tool may include the following areas

- » Analysis and testing
- » Specifications and structured design methodology
- » Critical thinking skills
- » Written specifications
- » Workflow processes and analysis
- » Documentation skills
- » Team focus and customer service
- » Leadership and communication
- » Professionalism

Based on these results, specific additional training may be recommended to assist staff preparation for the transition to the EHR. Appendix B is a sample of a skill gap analysis tool.

# **IMPLICATIONS FOR HIM**

A key factor in developing staff is identifying the functions and skills needed in each stage of the EHR. This toolkit uses the HIMSS EMR Adoption Model(SM) as a basis for identifying the implications of each stage as the organization transitions from a paper to a fully electronic system. The following stages identify the implications of the EHR implementation in each stage. Reviewing the implications will assist the HIM Director with determining what functions are needed throughout the HIM department at each stage. In conjunction with the employee assessment, this will prepare the HIM Director to accurately staff the department throughout the transition.



It is crucial to keep patient safety in the forefront as new systems and technologies are implemented and as the organization moves from stage to stage. As the organization moves from the paper health record to the EHR, a hybrid record is often created— part paper and part electronic. Policies and practices for efficiently managing the hybrid must be developed and implemented. Managing the hybrid record must be reassessed at every stage to ensure continuity of patient care. Ensuring health information is available to the provider when needed is also crucial. HIM must have processes in place to ensure the correct patient is identified when documenting or sharing information. Accurate health records are also needed for downstream uses such as HIEs, EHRs, and interfaces between systems. HIM must be active throughout all the stages as systems are implemented to ensure data integrity and accuracy. HIM professionals must ensure privacy and security programs are in place to promote patient trust and to meet overall compliance.

### **STAGES OF IMPLEMENTATION**

The following gives an overview of each stage as defined by the HIMSS model. The stages are used as a reference point; not every organization will follow each stage or implement all components within a stage before moving onto another stage. For example portions of stages 5 and 6 may be implemented even though CPOE from stage 4 has not been implemented. Each stage lists implications the HIM profes-

HIM professionals must ensure privacy and security programs are in place to promote patient trust and to meet overall compliance. sional may encounter and need to take into consideration as the EHR is implemented. This toolkit is set up to be utilized in stages; as organizations migrate through the EHR implementation, HIM professionals will be able to refer to the stage that matches the next phase.

### STAGE 0

The record is fully in paper and key clinical ancillary systems such as laboratory have not been implemented.

The HIM considerations and implications in this stage include

- » HIM has manual processes in place in nearly every function
- » Focus is on clerical staff
- » Filing records
- » Loose filing
- » Delivering information to the floors to be filed
- » Involvement in selection of EHR
- » Visioning the HIM department throughout the transition and consider creating a vision statement
- » Becoming involved in discussions at a high level assessing readiness of ancillary departments for future transition to an EHR
- » HIM participation in IT and health record governance
  - Planning and mapping how applications will go live (big bang, roll out—how to implement) and
  - Determine what steps need to be taken prior implementation
- » MPI clean up

### **STAGE 1**

Key clinical ancillary systems such as laboratory and others systems are installed.

The HIM considerations and implications in this stage include

- » Completing MPI cleanup prior to going live on clinical ancillary systems and EHRs
- » Developing a process for managing duplicates in the MPI
- » Beginning to gather all forms used in healthcare record
- » Determine implementation costs for budget considerations
  - Determine needs for additional computers, scanners, and printers
  - Physical department remodel considerations for equipment and staffing
- » Be involved in interfacing discussions for applicable ancillary systems
- » Print ancillary results to the floor

- » Print cumulative reports to the HIM department, manual collation, record look up, filing
- » Printing the health record and storing it in paper form. Beginning visualization exercises of how the department will operate by function (See appendix C for the "Sample Future State Questions for Staff Discussion.")

Clinical ancillary systems feed data to a clinical data repository (CDR) or EHR to provide access for reviewing results of the clinical ancillary systems. There is a medical vocabulary dictionary and a basic clinical support engine for basic conflict checking. Document management systems may be interfaced. The system may be HIE compatible and able to share data.

The HIM considerations and implications in this stage include

- » Beginning the hybrid record stage. It may be part paper and part electronic storing ancillary records in the system or part scanned record and part electronic storage of ancillary records in system
- » Considering patient safety issues as providers are reviewing both the electronic and paper record, and ensure the information is available
- » Ensuring accuracy in the enterprise MPI as multiple systems are implemented
- » Managing documents
  - Bar-coding
  - Document control through HIM to ensure consistency and standardization
  - Organization of the EHR and how information is indexed to be filed and retrieved
  - Chart correction processes for scanned documents and ancillary records
- » Stopping chart delivery if all components of the health record have been scanned and are available online
- » Identifying processes and staff authorized to correct records as needed
- » Beginning form evaluation and review for transition
- » Electronic signature considerations
  - Set up rules for electronic signatures.
  - Ensure that both electronic and printed documents include a statement similar to "electronically signed by" the date, and that both are visible and do not overlay other text.
  - Determine how the provider accesses documents to sign electronically.
- » Determining how physicians will access transcription or health record deficiencies
- » Setting up electronic work lists or tasks

- » Beginning to address HIM workflow changes at discharge, primarily
- » EDMS/CDR would impact filing, transcription, analysis, coding, ROI, and such, and it would also introduce new functions related to supporting the EDMS, if applicable
  - Determine what information needs to be scanned and turnaround time for each document type.
  - Analysis of records may be performed on scanned records
  - Auto fax through EHR, electronic document management system (EDMS) or transcription system
- » Considering whether paper folders for new patients still need to be created
- » Developing practices and policies for who will have access to print the health record
- » Coding may begin remotely utilizing scanned documents to review charts
- » Transitioning clerical staff to new functions
- » Redefining legal record and the location of documentation that makes up the legal record (paper, EDMS, ancillary records, and such)
- » Continuing the preparation and discussion with the HIM staff regarding the transition to the EHR
- » Beginning staff modeling exercises (see appendix D)
- » HIM leadership begins to evaluate how the EHR will impact the work flow and positions or job descriptions within HIM, as well as any discussion with human resources leadership regarding any changes to positions
- » Assessing employee readiness and willingness readiness (see appendix E for sample questionnaires for staff and appendix F for an example of numerically weighted criteria)

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Clinical documentation by nursing (for example, vital signs and flow sheets), nursing notes, care plan charting, and the electronic medication administration record (eMAR) system are implemented and integrated with the EHR/CDR for at least one service in the hospital. Rudimentary clinical decision support (CDS) is implemented for error checking (for example, drug/drug or drug/food). Medical image access from picture archive and communication systems (PACS) is, at least, minimally available for access by physicians outside of radiology via the organization's intranet.

The HIM considerations and implications in this stage include

» Maintaining a hybrid record with some of the record being available online and some still in paper format—patient safety still a consideration

- » Evolving hybrid record to include more electronic documentation and less scanning with nursing and clinical documentation online
- » HIM management team to lead the organization-wide initiatives for all clinical documentation in the EHR
- » Developing policies and practices for correcting and updating information in the records and providing corrected copies (may include HIEs and other EHR systems)
- » Ensuring processes for identifying duplicate health record numbers, which may increase as new systems are interfaced
- » Developing process for merging patient record numbers and their health records to be completed in all systems
- » Ensuring processes to validate interfaces between source systems and the EHR to include identifying correct patient data as well as accurate data transfer across systems
- » Recording management processes for creation, maintenance, retention, and archiving are developed and implemented
- » Beginning redesigning forms and templates to be integrated into the EHR
- » Ensure all information recorded is reproduced when releasing the information in either printed or other electronic form(for example CDs, HIEs, or portals)
- » Determining how information is structured in the EHR and how to reproduce this information in an understandable format
- » Developing policy for information displayed in graphical format but not stored electronically in the EHR (for example, decide whether a lab that was graphed by a provider in the EHR will be printed and scanned)
- » Continuing to redefine the legal health record, designated record set, and EHR as well as documenting all systems where the health record is either generated or stored
- » Determining practices and policies for how the health record will be created (for example, copy and paste or data pulled forward from previous encounters)
- » Identifying considerations for legacy systems that are difficult or impossible to integrate. HIM must be involved with the documentation requirements and ensure the information is appropriately integrated or stored in a retrievable format for patient care and safety
- » Transitioning this staff to new functions as less paper is generated to file in the paper record
- » HIM, in conjunction with the IT and the medical staff, determines when to stop printing ancillary and clinical information to the floors and for the paper record
- » No longer printing records has a tremendous impact on HIM since the largest majority of documentation in the medical record consists of nursing and clinical documentation and ancillary reports; continue transitioning staff

CPOE for use by any clinician is added to the EHR and CDR environment. The second level of clinical decision support capabilities related to evidence-based medicine protocols is implemented in at least one patient service.

The HIM considerations and implications in this stage include

- » Ongoing patient safety concerns with the hybrid record
- » Reviewing and updating verbal order policy. Educate, train and monitor
- » Becoming involved with order set development in CPOE by starting to identify top 25 DRGs, diagnoses, and procedures
- » Reviewing order set for "Do Not Use" abbreviations
- » Addressing verbal order processes to reduce the number of verbal orders, and ensure those that are given are entered and signed within 48 hours
- » Auditing to ensure correct type of order is selected
- » HIM must understand the unique terminology used by the EHR vendor (for example, closed orders as cancelled vs. discontinued upon discharge or signed by vs. authorized by) and educate staff across the organization
- » Assuring orders are set up to distinguish verbal orders versus protocol orders; This will have ramifications for required ongoing signatures of physicians for orders placed by nurses.
- » Considering reviewing for missing signatures for orders on a daily basis.
- » Automating of deficiencies for orders
- » Developing policy and practices to review verbal orders rejected by physicians
- » Reviewing printed records and ensure readable format
- » No longer basing HIM workflow on a physical record but on the hybrid record
- » Educating physicians on navigating the EHR to locate deficiencies, coding queries, and other messages or tasks
- » Ensuring HIM analysts understand where information is stored in the EHR
- » HIM analysts need to be able to assist providers with messages or tasks received via EHR

The eMAR environment is fully implemented. The eMAR, in conjunction with barcoding or other auto-identification technology, such as radio frequency identification (RFID), are implemented and integrated with CPOE and pharmacy to maximize point of care patient safety processes.

The HIM considerations and implications in this stage include

- » Involving HIM in the process of fully automating the documentation of the medication administration process to ensure that information presents in a way that assures appropriate representation of the medication administration process
- » Challenges printing the eMAR in a readable format
- » Printing eMAR and documenting on the paper causes issues.
- » Establishing strong controls to send back paper to the author to enter into the EHR directly; do not scan the printed record. Emphasize patient safety to encourage compliance.
- » Considering concurrent scanning of any paper-based information
- » Developing policies and practices ensuring all information that is printed for legal requests matches each time it is printed retrospectively. The health record is a longitudinal record and it is not necessarily encounter- specific. When printing the legal record for risk management and legal requests, print official copy of PDF file and print from the same file every time.

### **STAGE 6**

Full physician documentation (structured templates) is implemented for at least one patient care service area. Level three of clinical decision support provides guidance for all clinician activities related to protocols and outcomes through variance and compliance alerts. The PACS system provides medical images to physicians via an intranet and displaces all film-based images.

The HIM considerations and implications in this stage include

- » Discontinuing manual delivery of in-house transcription reports
- » Mailing and faxing printed records to the referring providers
  - Delivering notes to other providers electronically; providers can distribute notes to other providers without notifying HIM.
  - Developing policies and practices for tracking releases through the EHR that do not go through HIM
- » Fully implementing electronic signature
  - Ensure policies for electronic signatures are consistent for all electronic systems and are followed

- » Developing policies and practices for viewing and releasing preliminary reports versus final reports (transcription, ancillary)
- » Developing policies and practices to handle unsigned documents when a provider is no longer available to finalize the record
- » Discontinue printing the paper record
- » Identifying whether the EHR can automate deficiencies for provider documentation
  - Based on ADT messages or events in the EHR
  - Based on provider actions in the EHR
  - Can the process be concurrent
- » Developing processes for correcting deficiencies assigned to the wrong provider in the EHR
- » Releasing of information can be completed entirely from the EHR for current information
- » Involving HIM in template design to ensure documentation to accreditation and regulatory standards
  - Transitioning staff from chart processing responsibilities to more data integrity and quality of the health record
  - Reviewing and managing content
  - CDI becomes part of the EHR
  - Communications such as queries are sent electronically
- » Changing productivity standards within HIM for each function
- » Re-evaluating space requirement and possibility for smaller area for the HIM department
- » Designing virtual office (may have staff working from home)
- » Moving HIM to aggregating data and providing education in to improve outcomes and lower risk for both the hospital and the physician

The hospital no longer uses paper charts. The EHR is used to deliver and manage patient care through discrete data, document images, and medical images. Clinical data warehouses are used to improve quality of care and patient safety. Clinical information can be readily shared [e.g. continuity of care document (CCD)] with all entities that are authorized to treat the patient. The hospital has health information available for all services across the continuum of care.

The HIM considerations and implications in this stage include

- » Involving HIM in creation and use of the CCD. This may replace the transfer documents and may supplant the discharge summary.
- » Involving HIM in the development and use of data that resides in the clinical data warehouse
- » May connect with HIEs on EHR systems to share patient information and ensure the correct patient data is sent and received
- » Making patient portals available to share information—ROI may push records to portal or results may be sent automatically to patients.
- » Ensuring patient restrictions are honored for payers who may have access to the HIE
- » Ensuring patient restrictions are followed if accepted by the entity
- » Producing records for legal purposes to include e-discovery (meta data, audit trails and other behind-the-scenes information—versioning, redaction)
- » Documenting all systems used in the facility and how they are integrated and interfaced, where is the source data created
- » Documenting all records are created for the designated record set
- » Pulling appropriate data for outcome studies, abstracting information for registries, quality reviews, credentialing, etc.
- » Sharing clinical information in a readable format to the patient
- » Following retention and destruction polices and understanding when information is archived, how is it archived, and how it can be retrieved

# TRANSFORMATION

The transformation of HIM functions is complex. The path of change—moving from paper, to hybrid, to the electronic record environment—has many different twists. There is no one right way to do things. Making the changes will not always be efficient or perfect; in fact, it will be difficult and challenging at times. The tools in this document will facilitate HIM professionals in the transition to the future, measure progress, and explain and lead the transformational journey within their organizations.

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# **GLOSSARY OF TERMS**

Admission-discharge-transfer (ADT): The name given to software systems used in healthcare facilities that register and track patients from admission through discharge including transfer; usually interfaced with other system used throughout a facility such as an electronic health record or lab information system

**Bar-coding technology:** A method of encoding data that consists of parallel arrangements of dark elements, referred to as bars and light elements, referred to as spaces, and interpreting the data for automatic identification and data collection purposes

Clinical data repository (CDR): A central database that focuses on clinical information

**Clinical data warehouse (CDW):** A database that makes it possible to access data from multiple databases and combine the results into a single query and reporting interface

**Clinical decision support (CDS)**: The process in which individual data elements are represented in the computer by a special code to be used in making comparisons, trending results, and supplying clinical reminders and alerts

**Clinical document improvement (CDI):** The process an organization undertakes that will improve clinical specificity and documentation that will allow coders to assign more concise disease classification codes

**Computerized provider order entry (CPOE):** Electronic prescribing systems that allow physicians to write prescriptions and transmit them electronically. There systems usually contain error prevention software that provides the user with prompts that warn against the possibility of drug interaction, allergy, or overdose and other relevant information

**Continuity of care document (CCD):** The result of ASTM's Continuity of Care Record standard content being represented and mapped into the HL7's Clinical Document Architecture specifications to enable transmission of referral information between providers; also frequently adopted for personal health records

**Designated record set (DRS):** A group of records maintained by or for a covered entity that may include patient medical and billing records; the enrollment, payment, claims adjudication, and cases or medical management record systems maintained for or by a health plan; or information used, in whole or in part, to make patient care-related decisions

**Diagnosis-related groups (DRGs):** A unit of care-mix classification adopted by the federal government and some other payers as a prospective payment mechanism for hospital inpatient in which diseases are placed into groups because related

diseases and treatments tend to consume similar amount of healthcare resources incur similar amounts of cost; in the Medicare and Medicaid programs, one of more than 500 diagnostic classifications in which cases demonstrate similar resource consumption and length-of-stay patterns. Under the prospective payment system (PPS), hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual

e-Discovery: Refers to Amendments to Federal Rules of Civil Procedure and Uniform Rules Relating to Discovery of Electronically Stored Information; wherein audit trails; the source code of the program, metadata, and any other electronic information that is not typically considered the legal health record is subject to motion for compulsory discovery

**Electronic document management system (EDMS):** A storage solution based on digital scanning technology in which source documents are scanned to create digital images of the documents that can be stored electronically on optical disks

**Electronic health record (EHR):** An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one healthcare organization

**Electronic medication administration record (eMAR):** A system designed to prevent medication error by checking a patient's medication information against his or her bar-coded wristband

**Electronic signature:** A generic, technology-neutral term for the various ways that an electronic record can be signed, such as a digitized image of a signature, a name typed at the end of an e-mail message by the sender, a biometric identifier, a secret code or PIN, or a digital signature

**Enterprise master patient index (EMPI):** An index that providers access to multiple repositories of information from overlapping patient populations that are maintained in separate systems and databases

Health information exchange (HIE): The exchange of health information electronically between providers and others with the same level of interoperability, such as labs and pharmacies

**Interface:** The zone between different computer systems across which users want to pass information (for example, a computer program written to exchange information between systems or the graphic display of an application program designed to make the program easier to use)

**Master patient index (MPI):** A patient-identifying directory referencing all patients related to an organization and which also serves as a link to the patient record or information, facilitates patient identification, and assists in maintaining a longitudinal patient record from birth to death

**Meaningful Use:** A regulation that was issued by the Centers for Medicare and Medicaid Services (CMS) on July 28, 2010, outlining an incentive program for eligible professionals, eligible hospitals and critical access hospitals participating in Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use through a certified electronic health record technology

**Portable document format (PDF):** A file that is an electronic facsimile of a printed document

**Picture archiving and communication system (PACS):** An integrated computer system that obtains, stores, retrieves, and displays digital images (in healthcare, radiological images)

**Radio frequency identification (RFID):** An automatic recognition technology that uses a device attached to an object to transmit data to a receiver and does not require direct contact

**Release of information (ROI):** The process of disclosing patient-ide ntifiable information from the health record to another party

**Templates:** A pattern used in computer-based patient records to capture data in a structured manner

# APPENDIX A

### SAMPLE HIM JOB QUALIFICATIONS

Qualifications	Stages 0–1 Health Information Associate 1	Stages 2–3 Health Information Associate 2	Stages 4–5 Health Information Technologist 1	<b>Stage 6</b> Health Information Technologist 2	Stages 7 Health Information Specialist
Education	High School or GED diploma required	High School or GED diploma, required; Some college pre- ferred	Associates degree required; (BA degree a plus)	Associate degree in a related field required; or a Bachelors degree	Bachelor's degree in a related field
Experience	Some general HIM experience preferred	1–2 years experience in a healthcare set- ting or related field preferred	2–3 years experience in a healthcare set- ting preferred	1–2 years in a healthcare setting required; 2–3 years preferred	2–3 years in a healthcare setting required; 4–5 years preferred
Medical Terminology	Basic skills preferred	Basic skills required	Basic skills required; intermediate skills preferred	Intermediate skills required; advance skills preferred	Advances skills required
Analytical Skills	Basic skills required	Basic skills required	Applied skills required	Advanced skills required	Advanced skills require
Problem Solving	General skills required	General skills required	Advanced skills required	Advanced skills required	Advanced skills required
Attention to Detail	General skills required	General skills required	Wide range of skills required	Wide range of skills required	Wide range of skills required
Computer Skills	Basic PC proficiency skills required	Basic PC proficiency skills required and basic skills in Word, Excel and email preferred	PC proficiency skills required and basic skills in Word, Excel and email required	PC proficiency skills required and intermediate skills in Word, Excel and email required	PC proficiency skills required and ad- vanced skills in Word, Excel and email preferred
Content of Health Record		Working knowledge of the health record preferred	Detailed work- ing knowledge of the health record required	Detailed working knowledge of the health record and chart organization required	Detailed working knowledge of the health record and chart organization required
Regulatory Standards		Working knowledge of privacy regulations preferred	Working knowledge of documentation regulatory standards preferred, detailed privacy regulations required	Detailed knowledge of documentation and privacy regula- tions required	Detailed knowledge of documentation and privacy regula- tions required
English Language and Foreign Language	Written and spoken knowledge of the English Language required	Written and spoken knowledge of the English Language required	Written and spoken knowledge of the English Language required and bi- lingual preferred	Written and spoken knowledge of the English Language required and bi- lingual preferred	Written and spoken knowledge of the English Language required and bi- lingual preferred
Keyboarding	General skills	Intermediate skills	Intermediate skills	Advanced skills	Advanced skills

# APPENDIX A cont.

## SAMPLE HIM JOB QUALIFICATIONS

Qualifications	Stages 0–1 Health Information Associate 1	Stages 2–3 Health Information Associate 2	Stages 4–5 Health Information Technologist 1	Stage 6 Health Information Technologist 2	Stages 7 Health Information Specialist
Customer Service/ Communication Skills	Basic skills	Intermediate skills	Advanced skills	Advanced skills	Advanced skills
Specialized Skill Sets	Data analysis and research skills for error corrections preferred	Data analysis and research skills for error corrections required	Intermediate data analysis and research skills for error correc- tions required	Advanced data analysis and research skills for error correc- tions required	Advanced data analysis and research skills for error correc- tions required
Certifications/ Credentials			RHIT or other related credential preferred	RHIT or other related credential required, RHIA preferred	RHIA or other related credential required
Coding			Basic knowledge of ICD-9-CM (or ICD-10- CM/PCS) preferred	Basic knowledge of ICD-9-CM (or ICD-10- CM/PCS) preferred	Basic knowledge of ICD-9-CM (or ICD-10- CM/PCS) required
Hospital Systems/ EHR Systems		Basic knowledge of hospital computer systems and EHRs preferred	Basic knowledge of hospital computer systems and EHRs required	Intermediate knowl- edge of hospital computer systems and EHRs required	Advanced knowledge of hospital computer systems and EHRs required

# SAMPLE EXPLANATION OF LEVEL EXPERTISE

### LEVEL 1, HEALTH INFORMATION ASSOCIATE I

Performs health information activities necessary to organize, maintain, and use electronic and paper patient health records. Depending on area assigned, may specialize in one or more clerical functions including: maintenance of records in centralized location; filing, indexing, and scanning; chart retrieval; reconciling medical record activity. Accesses and updates electronic tracking systems. Answers telephones and assists with customer requests for medical records.

### LEVEL 2, HEALTH INFORMATION ASSOCIATE II

Performs health information activities necessary to organize, maintain and use electronic and paper patient health records. Depending on area assigned, may specialize in one or more clerical functions, such as qualitative or quantitative physician documentation review and tumor registry support and follow-up. Responds to requests for information and serves as customer service liaison. Queries multiple electronic systems to locate requested information. Working knowledge of the chart organization, content, and external requirements related to chart documentation and privacy.

### LEVEL 3, HEALTH INFORMATION TECH I

Performs specialized health information activities necessary to organize, maintain, and use electronic and paper patient health records. Depending on area assigned, may specialize in one or more clerical functions, such as coding clerical support, transcription processing and interface, coordination of record requests, image scanning quality auditing. Analyzes and researches errors. Participates in quality reviews. Compiles data and generates reports. Queries multiple electronic systems to locate requested information. Understands chart organization and content external requirements related to chart documentation and privacy.

### LEVEL 4, HEALTH INFORMATION TECH II

Performs specialized or advanced health information activities necessary to organize, maintain, and use electronic and paper patient health records. Positions at this level have high customer service, strong analytic and problem solving skills, require interpretation and explanation of policy and external requirements related to chart documentation, privacy, and release of information. Specific job responsibilities are based on the service unit assigned and include: release of information (ROI) to customers and patients, data integrity analysis and resolution (e.g., duplicate MRNs), analyzing and reassigning deficiencies when physicians are not assigned to the correct record deficiency, and assigning physician suspensions. Expert computer skills to navigate and query multiple electronic record systems.

### LEVEL 5, HEALTH INFORMATION SPECIALIST

Performs specialized or advanced health information activities necessary to organize, maintain, and use electronic patient health records. Positions at this level have high customer service and advanced analytic and problem solving skills; require interpretation and explanation of policy and external requirements related to chart documentation, privacy and release of information; and other departmental functions. Specific job responsibilities are based on the service unit assigned and include: release of information (ROI) to customers and patients, data integrity analysis and resolution (merging and unmerging duplicate records), monitoring interfaces and working failure reports. Expert computer skills to navigate and query multiple electronic systems.

# **APPENDIX B**

### SAMPLE SKILL GAP ANALYSIS TOOL

This sample tool may be used in lieu or addition to any commercial survey tools utilized by the organization. This sample tool may determine the readiness of the employee to transition to the EHR environment.

POSITION TITLE:	Instructions for Rating		Instructions for Level
	Level of Experience		of Competency
	Rate All Items in Each	Enter All Your Ratings	Put an "X" in the Level
	Core Skill Set Below	(number or X) in the	of Competency Box
	Using One Number	Gray Box	that Represents Your
NAME:	(1–10)		Level of Competency
			for this Skill Set:
DATE:			
			Beginner = 1,2,3,
TEAM LEADERS:			Intermediate = 4,5,6,
			Complex = 7,8,9,
			Expert = 10
	1 = Minimal Experience		
	10 = Maximum Experi-		
	ence		

	Lev -	el of				
	Expe	rience		Level of Com	petency	
	Min	- Max				
CORE SKILL SET	1	10	Beginning	Intermediate	Complex	Expert
Analysis/Testing	Example			X		
	Rating: 4					
<ul> <li>a) Performs detail analysis and data gathering.</li> <li>b) Thoroughly analyzes and tests data to evaluate the effectiveness of systems and procedures.</li> <li>c) Makes decisions and recommendations which reflect appropriate level of analysis and evaluation of options.</li> </ul>						

	Leve Expe	el of rience		Level of Com	petency	
	Min	- Max				
CORE SKILL SET	1	10	Beginning	Intermediate	Complex	Expert
Specifications/						
Structured Design						
Methodology						
a) Formulates system						
scope and objectives						
through research, inter-						
viewing and fact finding						
for feasibility and com-						
pleteness, identifying de-						
sired outcomes, require-						
ments, and conditions of						
satisfaction.						
Critical Thinking Skills						
a) Can identify major						
milestones and major/mi-						
nor project deliverables						
Written Specifications					ļ	
a) Prepares detailed						
specifications from						
which vendor systems						
will be configured and/						
or programs written. b)						
Prepares technical and						
user documentation.						
Analysis						
a) Documents existing						
workflow processes and						
provides analysis to im-						
prove processes.						
Documentation Skills						
a) Consistently and						
thoroughly documents						
and updates task statuses						
with detailed narrative						
on analysis, assignments,						
work completed, work to						
be done and communica-						
tion with users. b) Pre-						
pares training materials.						

	Leve Experi	l of ience		Level of Com	petency	
	Min -	Max				
CORE SKILL SET	1	10	Beginning	Intermediate	Complex	Expert
Team Focus &						
Customer Service						
<ul> <li>a) Participates effectively as a team member work- ing collaboratively within the team. Demonstrates knowledge of and com- mitment to team goals.</li> <li>b) Demonstrates flexibil- ity and adapts to chang- ing needs. c) Presents a cooperative and helpful attitude at all times to internal and external</li> </ul>						
customers.						
Leadership & Communication						
a) Communicates ap- propriately with various constituencies to accom- plish goals. b) Effec- tively communicates with external and internal customers. c) Accepts constructive criticism, adjusting performance/ behavior in response to such criticism.						
Professionalism						
a) Represents Health Information in a profes- sional manner, including demeanor, dress, code of conduct. b) Acts as an ambassador for (employ- er name) while at work and at (employer name)'s sponsored events.						

# **APPENDIX C**

### SAMPLE FUTURE STATE QUESTIONS FOR STAFF DISCUSSION

These are sample questions to solicit responses from staff during the initial planning phase for purchasing an EHR. After the initial implementation, HIM management may refer back to these questions as additional functionality is implemented within the EHR.

Script for HIM Director: We will be meeting to discuss the future functions of HIM services. Please be prepared to discuss your thoughts. The following questions are a guide for this discussion.

- 1. What functions do you think will be needed to support the electronic health record
  - a. In the next year?
  - b. 2 years?
  - c. 5 years?
  - d. Think about current processes; for example, will there be the same amount of paper to handle in 5 years?
  - e. What new functions will need to be performed to support the electronic health record or other new functions?
- 2. In preparing your thoughts about the department, imagine that this is a brand new department to staff. Do not think of people that are already here, think of positions we need to perform the functions within an EHR.
  - a. When will staff need to be at the hospital?
  - b. What job functions will they need to perform?

### 3. Think about the new workflow for your area.

- a. What will be your workflow challenges
- b. How would you like to solve them?
- 4. What is missing to achieve your goals?
- 5. Based on current statistics within your section, be prepared to think about the number of FTEs needed to do the new functions.

# **APPENDIX D**

### SAMPLE HIM DEPARTMENT FUTURE STATE MODELING EXERCISE

These are not recommended staffing standards; this is only an example of how you may assess the need in your department.

Current State Processes	Future State Processes	Positions Now	Positions Needed	Gap Analysis
Filing	No	6	0	-6
Chart Retrieval/Filing	Yes—temporarily	4	1	-3
Scanning QC/Prep Customer Service	Yes	2	8	6
Transcription Coordinator	Yes	1	1	1
System Maintenance—MPI/ Physician Master/Guarantor Changes	Yes	1	2	1
Coding	Yes	15	15	0
Clinical Documentation Improvement	Yes	2	2	0
Analyst/Abstractors/ Incomplete Records	Yes	6	5	-1
Transcription	Yes	22	24	2
Release of Information	Yes	3	3	0
Registries	Yes	3	3	0
Data Base Quality	Yes	1	1	0
Forms	Yes—some forms during transition and then focus on downtime forms	1	1	0
Security	Yes	1	2	1
HIM System Administrator/ Analyst	Yes	1	1	0
Managers	Yes	4	5	1
Total		73	74	2

# **APPENDIX E**

### **SAMPLE QUESTIONNAIRES**

The next two questionnaires are used to identify staff who are able to change. These questionnaires are based on job functions. These questions are used to look for the ability to verbalize understanding of the scanning process and what it means. Did the employee listen to the training and comprehend it or is the employee just following the steps with no understanding? Understanding the criticality of different document types (which had a priority and why), independent thinking and problem solving (how do you systematically work through different scanner problems rather than just 'asking the supervisor' to fix the issue) and understanding of release of information.

There are a couple of questions that refer to which site employees preferred to work (applicable where there are multiple sites). This may sound like a benign question, but if the HIM department is centralizing operations to one campus, it may be important to identify staff who are willing to relocate. This question may also be used to demonstrate rigidity and inability to accept change.

Adding a numeric score to each of the elements helps retain some level of objectivity. Scoring is complete by number of correct answers on a scale from 1–5. If all answers are identified, a minimum of a three is given. If an answer is incomplete, points are deducted. For example, how often should you go and pick up charts? Every 30 minutes would score a 3, several times a day score a 2, no answer or incorrect answer 0. A four may be scored if the employee adds additional information of value, such as run charts every 30 minutes, but if one is needed for care immediately, the chart is taken to the clinic right away.

### SAMPLE QUESTIONNAIRE FOR MANAGER TO ASK CLERICAL STAFF

# **EMPLOYEE:** Question: How often should you go to the clinic to deliver or pick-up charts? Answer (must answer to score a 3): O Every 30 minutes Comments: Score: 1 2 3 4 5 Question: What are the four key documents that require a chart for a new patient? Answer (must answer all four to score a 3): O Immunization Record O Growth Chart O Medication Record O Problem List Comments: Score: 1 2 3 4 5 Question: The clinic calls and they need a chart. You check Chart Tracking, and it indicates that it is signed out to that clinic. What do you do? Answer (must answer all three to score a 3): O Check the Permanent File O Go to the clinic to check if it is there O Start looking for a misfile Comments: Score: 1 2 3 4 5 Question: You notice a customer waiting at the front of the department and there is no other HIM staff around, how do you respond? Answer (must answer all three to score a 3): O Ask the customer of he/she has been helped O Help the customer if you are able O Offer to find (and find) a coworker with the ability to help him/her Comments:

Score: 1 2 3 4 5

### SAMPLE QUESTIONNAIRE FOR MANAGER TO ASK CLERICAL STAFF (CONT.)

Question: Name the methods you would use to help locate a misfiled chart: (Example: 829904)

Look (must answer all four to score a 3):

O In all the charts in that section (same terminal digits: 04's)

 ${\rm O}$  In all the charts of the same color in that section (tan 00's to 09's)

O In the sections where the terminal digits could have been transposed (40's)

 ${
m O}$  In the sections immediately before and after (03's and 05's)

Comments:

Score: 1 2 3 4 5

Question: Why should we hire you? (No score, but may be used if needed)

Answer/Comments:

Overall Score: 1 2 3 4 5

### SAMPLE QUESTIONNAIRE FOR MANGER TO ASK FILING STAFF

EMPLOYEE:
Question: When you start your shift there is several piles of prepping to complete: ED, inpatients, same day surgery and clinics. How do you prioritize this work? <i>Or</i> In what order would you complete the prepping of these patient types?
Answer (must answer all four in sequence to score a 3):
O ED
O Inpatient
O Same Day Surgery
Comments
Score : 1 2 3 4 5
Question: While prepping, you notice a form without a barcode; what do you do?
Answer (must answer to score a 3): O Print a document cover page
Comments:
Score: 1 2 3 4 5
Question: The clinic calls and they need a chart. You check Chart Tracking, and it indicates that it is signed out to that clinic. What do you do?
Answer (must answer all three to score a 3):
O Check the Permanent File
O Go to the clinic to check if it is there
O Start looking for a misfile
Comments:
Score: 1 2 3 4 5
Follow-up Question: What if there is no document cover page in print queue?
Answer (must answer in sequence to score a 3):
O Check the crosswalk for the form and use the document cover page is listed
O If you don't see the form on the crosswalk, check the Hierarchy
O If you still don't see the form, don't scan it, and show it to your supervisor
Comments:
Score: 1 2 3 4 5

### SAMPLE QUESTIONNAIRE FOR MANGER TO ASK FILING STAFF (CONT.)

Question: What actions do you take if the equipment is not working properly?
Answer (must answer both to score a 3):
O Call the Help Desk
O Notify my supervisor, manager, or manager on-call
Comments:
Score : 1 2 3 4 5
Follow-up Question: Is there anything else you would do?
Answer (must answer to score a 3):
O Review the message on the equipment and consult the trouble-shooting book/manual
Comments:
Question: A coder or abstractor contacts you and reports that an H&P is scanned into the Consultations folder. What do you do?
Answer (must apswer all in sequence to score a 2):
$\Omega$ Check the EHR to confirm that the document was scanned into the wrong folder
O Print out the document
O "In Error" the document in the EHR
O Rescan the document into the correct folder
O Check the EHR to confirm that the document was rescanned into the correct folder
Comments:
Score : 1 2 3 4 5
Question: A chart has been scanned and is not yet viewable in the EHR. The ED calls and needs to see the scanned record. What steps do you take?
Answer (must answer in sequence to score a 3):
O Ask the ED exactly which documents they need and make a copy of the originals (if it's urgent) and send/ deliver copies to ED (keep originals in HIM)
O Check to see if the chart has been scanned
O If scanned, check to see if it has been through quality control process
O If scanned guality centrel was performed more than 15 minutes age, call the Help Deck (may indicate a
system problem)
Comments:
Score : 1 2 3 4 5

### SAMPLE QUESTIONNAIRE FOR MANGER TO ASK FILING STAFF (CONT.)

Question: You are working alone on a Saturday afternoon, and a parent walks in and requests a copy of his child's medical record ( <i>the whole chart</i> ). How do you respond to the parent?
Answer (must answer all three to score a 3):
O Have the parent fill out an authorization for release
O Explain to the parent that release requests are processed Monday-Friday
O Give the parent the phone number for the release of information staff
Commonts:
Comments.
Score : 1 2 3 4 5
Question: A unit calls, and a child is being transferred to a different facility. What are your responsibilities?
Answer (must answer all four to score a 3):
O Make sure there is an authorization for release of information
O Print pertinent (or last three days) information from the EHR
O Go to the unit and copy pertinent (or last three days) of handwritten notes and orders
O Make a copy of the authorization for release of information to send along with copies
(original authorization is filed in the Children's chart)
Comments:
Comments.
Score : 1 2 3 4 5
Question: A subneana for a modical record is served on the department. How do you respond?
Question. A subpoend for a medical record is served on the department. How do you respond?
Answer (must answer all four to score a 3):
O Make sure there is an authorization for release of information with the subpoena
O If the authorization is present, forward to ROI staff or manager for processing
O Can REFUSE the subpoena if there is no authorization for release
O Subpoenas "in the matter for the welfare of" do not require an authorization for release
Comments:
Score : 1 2 3 4 5
Question: In the middle of your shift you notice that everything has been prepped and scanned, there are
no charts to deliver or file, and the phone is not ringing. What do you do until the end of your shift? Or
What tasks or projects are there to work on?
Answer (must answer all three to score a 3):
O Check the scanning room for any prepping that needs to be done
O Go to the ED/same day surgery units to check for visits that need to be prepped
O Ask manager/supervisor for any new projects or additional work
Community
Comments:
Comments:
Comments:

AHIMA

Score: 1 2 3 4 5

### SAMPLE QUESTIONNAIRE FOR MANGER TO ASK FILING STAFF (CONT.)

Question: These positions require rotation between campuses. Tell me how you will manage this type of schedule.
Answer/Comments:
Question: What is your schedule preference? And/or are there any days or hours that you are not willing to work?
Answer/Comments:
Question: A subpoena for a medical record is served on the department. How do you respond?
Answer/Comments:
Question: Why should we hire you?
Answer/Comments:
Overall Score : 1 2 3 4 5

# **APPENDIX F**

### SAMPLE WEIGHTED SCORES

This sample scoring tool is used to rate employees on their readiness and willingness to transition to new functions in the EHR. The interviews in conjunction with this table provide an object measure for employee assessment. The form to rate employees is below.

### **INSTRUCTIONS:**

- 1. Pick the appropriate score from each column.
- 2. Record selected score on the Employee Weighted Score Sheet below.

Years of Service/HIM Experience	2012 Review Overall Rating	2011 Review Overall Rating	Disciplinary Action If multiple actions, add all together	Degree in a Health Related Field	Certification Consider: RHIT, RHIA, CHDA, CDIP, CCA, CCS, CCS-P, CHPS
1	-3	-3	-4	0	0
0–2 years and 11 months	Unsatisfactory	Unsatisfactory	Suspension	None	None
2	-2	-2	-3	1	1
3–9 years and 11 months	Needs Improvement	Needs Improvement	Written Warning	Partial or coding certificate	RHIT only
3	1	1	-2	2	2
10+ years	Meets Expectations	Meets Expectations	Verbal Warning	Associate's Degree	RHIT with additional certification
	2	2	-1	3	3
	Above Average	Above Average	Counseling	Bachelor's Degree	RHIA with additional certification
	3	3	0	4	
	Outstanding	Outstanding	N/A	Master's Degree	

### SAMPLE FORM EMPLOYEE WEIGHTED SCORE SHEET

Employee Name:	Years of Service/HIM Experience	2012 Review Overall Rating	2011 Review Overall Rating	Disciplinary Action	Degree in a Health Related Field	Certification	Interview Score	Total Score