



19 Aviation Road
Albany, NY 12205-1142

(518) 435-0422
Fax (518) 435-0457

www.nyhima.org



Perspectives Online

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FROM THE PRESIDENT



Greetings to all! I hope this message finds you surviving the journey towards HIPAA/HITECH, meaningful use, and, last but definitely not least, ICD-10.

Here is an update on the various initiatives we have been working on since last we

saw each other in June, which seems like it was just yesterday.

In July, Karen Fabrizio and I traveled to Chicago to attend the AHIMA summer team talks/leadership conference. One area of focus, strategic planning activities, really struck a chord with both of us. A message that resonated was "How do we spend our time as a Board and as an Association? Are we constantly working towards achieving our strategic goals or identifying the barriers that prevent us from reaching the initiatives we outline for our members each June?"

We took the message and tools we learned at summer team talks and applied them to our September Board/Local Leaders/Strategic Planning meeting and, over two days, came to the agreement that making sure all of our activities are tied to our strategic plan will help us to succeed in fulfilling our mission (see the 2010-11 plan on the Website at: <http://www.nyhima.org/pdf/files/1011strategicplan.pdf>.)

Karen has taken the excellent information we gathered during our strategic planning session to incorporate into the strategic plan for her term as President in 2011-2012.

Fresh on the heels of this planning retreat, your delegates were off to Orlando to represent the interests of the members at the AHIMA House of Delegates. Two major issues were on the agenda for debate and vote: apportionment for the House and a name change for AHIMA. The Nebraska HIMA had proposed a bylaw amendment on the House of Delegates apportionment and a contingent motion

on composition of the House. The New Jersey HIMA moved to amend the pending Nebraska amendment for the Senate apportionment model by striking out the language of the original bylaw amendment and inserting new language based on a thirds model (this would divide the House into thirds – small, medium and large CSA – with the delegate count based on membership total). A counted vote was conducted with the result being a defeat of the amendment.

The Tennessee HIMA had proposed a bylaw amendment to change the name of AHIMA by inserting the word 'informatics' into the association name, making the name *American Health Informatics and Information Management Association (AHIIMA)*. The proposed amendment required a two-thirds majority vote to adopt. A counted vote was conducted with the result being a defeat of the amendment.

Thank you to all the members of the Board, committee chairs, local leaders, and Central Office staff for their hard work this fall. Thanks to their efforts

- ❖ an online membership product is near completion;
- ❖ strong education sessions are being conducted;
- ❖ alliance-building is underway with the Medical Society (MSSNY) and medical practice managers (MGMA);
- ❖ groundwork is laid for ICD-10 training initiatives ([watch for dates that AHIMA will be conducting I-10 Academies in New York in the fall of 2011!](#));
- ❖ 2011 annual meeting planning is progressing nicely;
- ❖ the nominating committee is preparing the ballot for your slate of officers in 2011-12; and
- ❖ we've joined AHIMA's CSA I-10 Medicaid project to make certain Medicaid is ready for implementation.

Moving forward, we'll be looking for your input as we put together some surveys, including how best to use the media available to us; i.e., newsletter content vs. blogs/live chats. Please be sure to respond and share your thoughts and ideas.

Tracy L. D'Errico, RHIA

IN THE NEWS

On the State Front

NGS Special Notice for NY Providers

The Clinical Education area of the National Government Services Website carries a notice on Medical Necessity for Inpatient Stays and the Eight-Hour Rule for Observation Services. Please note that it applies to Jurisdiction 13 New York providers only. The posting addresses concerns regarding the potential for a payment and policy conflict between Medicare's medical necessity requirements for inpatient admission and the State of New York's law relating to observation services (Eight-Hour Rule).

Copy and paste the following URL into your Web browser to access the posting:
<http://www.ngsmedicare.com/content.aspx?CatID=1&DOCID=21970>.

Submitted by: Tracy L. D'Errico, RHIA [LIHIMA]

NYS DOH Submits Plan for EHR Network

The New York State Department of Health and the New York eHealth Collaborative have submitted a plan to the Office of the National Coordinator for Health Information Technology to create a \$129-million statewide electronic health record network.

Approval of the plan (expected before the end of the year) by CMS would be the first step in New York's effort to connect existing regional networks of EMRs. The proposal calls for new infrastructure and programming, and state agencies would oversee policy development for implementation and maintenance. Five state and federal grants will fund the project, with federal monies accounting for \$75-million.

Source: Health IT Strategist, Modern Healthcare's Daily IT e-Newsletter, October 27, 2010

On the National Front

HI&T Week



Mark your calendar for Health Information and Technology (HI&T) Week, sponsored by AHIMA and the Canadian Health Information Management Association, with the support of Perceptive Software. This

annual event is a showcase for the thousands of HIM professionals who perform their duties masterfully throughout the year.

Use the following URL to access **free materials** from AHIMA that will help spread the message and enhance your participation in the celebration:
<http://www.ahima.org/events/recogweeks.aspx?tab=2>.

AHIMA NEWS AND INFORMATION



Reports from the House of Delegates

AHIMA HOD Best Practices/Standards Team

The Best Practices/Standards Team met on September 26, 2010 at the Gaylord Palms in Orlando, Florida. I was appointed Co-Chair of this House of Delegates Team. The Team's charges were as follows:

- ❖ Collaborate with the Practice Councils, Professional Ethics Committees and related volunteer groups on the development of HIM practice guidance and professional guidelines
- ❖ Review submitted resolutions and develop resolution concepts
- ❖ Include AHIMA Foundation research initiatives in discussion
- ❖ Support the Action Community for e-HIM[®] Excellence (ACE) by identifying topics for ACE members' discussions, activities, etc.

Similar to the other House Teams, our team is making great progress. We have spent time reviewing and providing feedback on a practice brief. We are serving as a review body for HIM practice guidance developed by the American Health Information Management Association's e-HIM Workgroups and/or Practice Councils. On our conference call held in August 2010, we received a preview of the e-HIM Compendium that will be demonstrated during the AHIMA convention. House of Delegate members were encouraged to visit the AHIMA booth for a detailed demonstration of the e-HIM Compendium. We also continue to review and discuss the resolutions passed by the House and much of this work will be on future Team meeting agendas.

Support and recommendations are being made regarding the ACE (Action Community for Excellence) program. We are looking for ways to increase the value and visibility of the ACE program. One of our team charges is to support the ACE program by identifying topics, discussions, activities, etc. ACE is a community of experts who agree to serve as resources by mentoring, speaking, writing, testifying, and undertaking advocacy. There are a lot of opportunities for ACE members, including

- ❖ Participating in regional HIE activities,
- ❖ Speaking at state or national HIM conferences, and
- ❖ Collaborating to advance HIM practice, mentoring students and other professionals.

Being an ACE member gives me an avenue to promote the visibility of HIM professionals, demonstrate leadership, provide mentoring, and achieve professional growth. Mentoring is an excellent way to give back to our profession and this is the reason why I joined the ACE program.

Are there any topics you would like us to consider? What other activities can you think of to engage ACE members? Please send me an email (restrella@nygio.sdps.org) with your suggestions. And use the ACE Directory as a resource for interviews, article writing, speaking, and mentoring.

Submitted by: Renato L. Estrella, MSHA RHIA FAHIMA [LIHIMA]

AHIMA HOD Higher Education and Workforce Team

Our group met face to face on September 26 at the annual convention in Orlando, Florida, to discuss the current topics facing educators and student in the future. The main issue on the table is providing meaningful Professional Practice Experience (PPE). Many states continue to struggle with placing students in traditional and non-traditional settings.

New York's suggestion, to add a field to our membership application where a member could list if they were willing to take students and be added to a searchable item list in the membership database, was well received. Other members in the group and expanded on the idea to have AHIMA investigate putting this type of field on its membership form and, possibly, allow students and educators to search out willing practicum sites from the website. This would be valuable to those students enrolled in online courses.

Discussion continues around how to make part of the PPE virtual in order to accommodate those non-traditional settings where all the roles of an HIM department may not be available to review in an onsite environment. All members of the workgroup agree this experience is what makes our profession different from others and that it must be retained as part of the education of HIM students. This will be a topic on the Team's agenda for the coming year.

The PPE guidance document updates are in progress and are expected to be released by year's end. The guide has been well received by all in the field.

The updated guide is expected to contain an expanded appendix with more practice examples for potential projects students can work on. It is also expected to clarify that up to five (5) continuing education credits can be earned by those

credentialed members who spend time training students. If anyone would like an advance copy, please send me an email (jbrucker@setonhealth.org).

Submitted by: Julie L. Brucker, RHIA CCS [AdHIMA]

AHIMA HOD Operations Team

This was my first year on the national scene and it was a little overwhelming at the beginning. There were two topics to be voted on at the House of Delegates, and it was obvious from the emails and discussion threads on the CoP that it could become very interesting. The item on the name change alone sparked controversy among the states, but I was surprised to see the amount of passion behind the motion to change the delegate voting strength for each state.

Although I had experience with Roberts Rules of Parliamentary procedure before attending the HOD, this meeting definitely gave me new insight. A motion was brought by Nebraska to change the voting strength to a senate model; that motion was amended by another one to change the wording from senate to thirds. The challenge came in knowing which vote would come first – the original motion or the amended one. Our fearless President, Tracy D'Errico, didn't hesitate to invite the Parliamentarian to our table to give us a mini lecture on the voting sequence. As a group, we were concerned with the voting strength of the AHIMA Board if the senate model were voted on; we wanted to make sure we knew the appropriate time to introduce a motion to the senate model. Did you know that all motions have to be seconded, even at AHIMA's HOD? The paperwork needed to be completed prior to the motion being formally introduced. I can see how some of our politicians must feel when they are trying to build support for their bills! Fortunately, our motion was not needed once the thirds amendment was voted down, thereby suppressing the senate model issue. During the meeting it was interesting hearing the stories from last year's House when Julie Brucker tried to ask a question and was not recognized by the Chair until later. Although they did not officially name the additional microphone after her, they definitely alluded to the situation!

It's going to be a challenge to ensure we are able to follow Robert's Rules as we move toward an electronic and virtual HOD at AHIMA. This is one of the items the Operations Team will focus on in the upcoming months. We want to make sure every aspect of making a motion, an amendment, and open forum for debate is followed and no delegate is excluded or not heard. At the NYHIMA HOD we have had some passionate discussions and debates while entertaining various motions. The protocols and guidelines established by AHIMA will definitely affect us at the state level so it is

important for us that we are involved in their establishment.

The HOD Operations Team is continuing their work on the delegate toolkit, survey and evaluations. I have already raised a question relating to the expectation for participation in conference calls and onsite meetings. There had been discussion about raising it to 100% or the high 90%*s*. I personally do not feel it is appropriate for 100% participation in the onsite teams as no state has enough delegates to assign to each of the existing six teams. The response was that we can assign a non-delegate member and have a substitute sit in when the assigned delegate is unable. As a new member to the club, it is overwhelming enough for me to participate effectively – I think it would be even harder for someone to jump in and participate without prior background.

I am very grateful for this opportunity to participate on the national level and I look forward to representing our members in the coming months.

Submitted by: Karen L. Fabrizio, RHIA [CNYHIMA]

House of Delegates Action Forum Groups Leadership Development/Academy

This year the AHIMA convention was held in sunny Orlando, Florida! Similar to the NYHIMA HOD, AHIMA develops topics for breakout sessions that delegates can attend so that AHIMA can solicit input on various areas from its members. Your delegation tries to attend as many of the action forums as it can so that we both gather information to bring back to our members as well as provide input to the national on your behalf.

The Leadership Development/Academy Action Forum is related to the Volunteer and Leadership Development HOD Workgroup. Since I am one of the current co-chairs for this workgroup, I was asked to facilitate the morning session. In this action forum we discussed the recruitment and balloting processes of the CSAs and AHIMA. We asked: “Do you have a slate of candidates, two candidates per position, or more?” “If you offer a slate, is it because you cannot recruit more than one candidate, or is it an intentional process of grooming leadership?” Also, related to leadership, AHIMA is considering an online Leadership Academy with the use of Franklin Covey materials and facilitated discussion by AHIMA Fellows and members of ACE.

The discussion on CSA ballots indicated that most of the CSAs have the same issues trying to fill in a ballot for each of the positions on their Boards. Some CSAs have changed their Bylaws so that they are not required to offer two candidates for each position since they were having issues finding enough members willing to run. Diversity and how the CSAs try to incorporate that into their ballots

was also discussed. CSAs try to have variety in where the candidates work – vendors, acute care, long term care, consultants, etc. – as well as geographic considerations so that a better cross-section of members is represented on the ballot and, ultimately, on the Board. These types of ballot issues are seen at the local/regional, state, and national levels of AHIMA. Each CSA continues to be creative as it tries to offer a ballot that reflects its members but also as it tries to get members who can and will commit to running on the ballot and serving the Association at the various levels. The Volunteer and Leadership Development HOD Workgroup has also developed competencies for some positions (President/President-Elect, Treasurer, Committee Chair, and Delegate) – would CSAs be willing to use these to give their members the opportunity to determine if they are qualified to run as well as assisting the CDA Nominating committee in finding qualified individuals? CSAs vary in the make-up of their nominating committee as well. Some are similar to ours in New York and others have a separate committee not made up of local presidents as ours is.

The AHIMA Board has proposed the development of a Leadership Academy to help ‘grow’ our members and increase the pool of potential leaders for the various Board positions at the local/regional, state, and national levels. A series of webinars would be developed using Franklin Covey videos as the basis and incorporating AHIMA Fellows and ACE members to share experiences and facilitate discussion around the videos. They would possibly be offered monthly or quarterly as a series, similar to AHIMA audio-seminars, 90 minutes at \$179 for members and discounted rates for packages of multiple webinars and/or archived webinars. This proposal was enthusiastically supported by those present at the action forum.

Please feel free to contact me (donna.rugg@thompsonhealth.org) if you have questions or input on either of these topics. Both of them will be future discussion topics on my HOD Workgroup so I am always interested in hearing from our members in order to continue to represent you in our AHIMA activities! And I’d encourage you to consider getting involved and running for an office or serving as a Committee chair in your local, at NYHIMA, or AHIMA – the benefits and rewards are priceless☺.

Submitted by: Donna J. Rugg, RHIT CCS [RRHIMA]

The HIM Role in EHR and HIE

HHealth Information Exchange (HIE) is defined as a term used to describe both the sharing of healthcare information electronically across organizations, communities, or among two or more regions/entities. It provides services that enable the sharing electronically of health information. The ability to exchange health information electronically

is an effort focused on initiatives in technology, interoperability, and standardization.

The HITECH provisions of the American Recovery and Reinvestment Act (ARRA) have raised a national interest and activity in health information technology (IT) and health information exchange (HIE). States require a coordinated plan to encourage the adoption and "meaningful use" of electronic health record (EHR) systems in a manner that directly benefits patients, providers, agents, and advocates.

Some challenges that were discussed during the AHIMA House of Delegates Action Forum held in Orlando, Florida, in October 2010, were as follows:

- ❖ Data Integrity
 1. When is the record complete?
 2. How do you prevent duplication of effort?
- ❖ Competition within the States
 1. Non-willingness to share information
- ❖ Accreditation Standards
- ❖ HIM Not Involved

The Health Information Exchange provides the opportunity to electronically exchange clinical information to ensure the accuracy of the information being exchanged. The infrastructure for secondary use of data for purposes such as biomedical surveillance, consumer health informatics research and public health reporting will be provided.

Why An Electronic Health System?

The electronic health record system has the capability to transform the ways in which care is delivered. EHR affects all aspects of healthcare delivery and should not be viewed as an IT application but, rather, as a tool to revolutionize the healthcare system. The implementation of an electronic health record system can make a patient's record available when and where it is needed – it brings all of a patient's information together in one place.

The HIM profession is changing. HIM roles and responsibilities are moving forward as advancements are made in healthcare delivery systems. HIM professionals can facilitate the design and maintenance of privacy and security practices, record retention activities, release of information activities, and other fundamental core competencies of the profession in both new and established HIEs.

The forum on the HIM role in the EHR and HIE identified current challenges with regard to HIE, including lack of agreement on record completion and lack of willingness to share information as well as the need for accreditation standards to protect information and consumers. Participants in the action forum identified some tasks for HIM professionals to take action on:

- ❖ Help develop standards for data integrity and security
- ❖ Participate in CSA discussions to lead the way

- ❖ Educate members on how to advance standards-based solutions
- ❖ HIM professionals need to be at the table
- ❖ Educate patients and consumers, policy makers, and ourselves about HIEs
- ❖ Establish a statewide 'Hill Day' in all states to increase state-level advocacy

The Electronic Healthcare Network Accreditation Commission (EHNAC) is developing an accreditation program for health information exchanges, regional health information organizations, and other community-based networking partnerships. EHNAC is a voluntary, self-governing standards development organization (SDO) established to develop standard criteria and accredit organizations that electronically exchange healthcare data. These entities include electronic health networks, payers, financial services firms, health information exchanges, and e-prescribing solution providers.

Health information exchange enables public health to meet its commitment to improve the quality of healthcare delivery for patients and our nation's healthcare system in improving outcomes and cost savings.

Submitted by: Renato L. Estrella, MSHA RHIA FAHIMA [LIHIMA]

NYHIMA NEWS AND INFORMATION

Congratulations To

Alison S. Nicklas, RHIA CCS on the August 4 birth of her grandson, Owen Peter Lapsa.

Tenille Schmitt, [HIMANNY] on the August 11 birth of her daughter, Hailey Marie.

Lance Smith, RHIT CCS-P CHC [SENYHIMA] on being recognized as one of AHIMA's Top CoP Facilitators for 2010. This is the fifth time in the past six years that he has received this designation.

2011 Annual Conference



This year's conference — **'One Purpose. One Vision. Together . We Can Do More'** — will be hosted jointly by the four downstate locals – Long Island, New York City, Southeastern, and Tappan Zee – June 5-8, at the Hilton Rye Town Hotel, 699 Westchester Avenue in Rye Brook

(Westchester County).

The program and arrangements committees have been hard at work over the summer to develop timely and interesting topics for the educational sessions and fun activities for your 'downtime.'

If you're interested in volunteering on a planning committee and/or onsite during the conference, please send your contact information to Renato Estrella, Annual Conference Chair **by January 15** (restrella@nyqio.sdps.org) and let him know where you might be available to help out.

For a 'sneak preview' of the meeting venue, copy and paste the following URL into your Web browser, http://www1.hilton.com/en_US/hi/hotel/RYEHIHH-Hilton-Rye-Town-New-York/index.do, and visit the hotel's Website. Then watch the NYHIMA Website for announcements of the preliminary program and registration information. Mark your calendar now and plan to be part of the excitement as NYHIMA comes to New York's Golden Apple area!

FYI: Q&A: Releasing Records to Attorneys

[Editor's Note: The following was answered by Mary D. Brandt, MBA RHIA CHE CHPS. It is intended to provide general information only and should not be considered legal advice.]

Q: When an attorney requests we release all records, must we comply and send all of the patient's medical records?

A: If the attorney's request is accompanied by the patient's authorization, review the authorization to determine what information the patient consented for release. If the patient's authorization states that you may release 'any and all records', you must still apply minimum necessary criteria. Contact the attorney to determine which records he/she needs and release only those records. If the patient's authorization specifies release of a limited subset of records, you must comply with the authorization, even if the attorney requests more information. If a subpoena seeking 'any and all records' accompanies the attorney's request, you must apply minimum necessary criteria.

*Source: HCPPro Compliance Monitor
Volume 13, Issue 30, August 4, 2010*

FROM YOUR PEERS

My Joint Commission Experience

I had the pleasure of recently going through a Joint Commission Survey! This year I was surprised to have to actually meet with surveyors to explain our record review process. In the past two surveys I have gone through I did not see the surveyor at all. This time they wanted to see the record review reports that are submitted quarterly and asked how the information is provided up to the medical staff and administration. They used this information when they went on the tracer and actually looked at the items we had identified as problems, which then appeared on our preliminary report. We are still waiting for the final report and we expect to be cited for not having all entries dated and TIMED, including progress notes, consent forms, orders and nursing notes; illegible SIGNATURES for the medical staff

and illegible handwriting; and, of course, not dating and timing telephone orders within 48 hours.

We are expecting a full report any day now and then I expect to be auditing for quite some time. If anyone has new suggestions for these common issues – or maybe a success story you are willing to share – it can help all of us. I welcome you to share your stories if you have had a similar experience – save us from audit mania!

Submitted by: Julie Brucker, RHIA CCS [AdHIMA]

Transcription Lends a Helping Hand in EHR Implementation

The University of Rochester Medical Center (URMC) is moving to a completely electronic health record (EHR) and, as a result, it is guaranteed that their provider documentation will change. What is unknown is exactly how providers will adapt to new ways of capturing data and documenting encounters.

Provider documentation, captured primarily by dictation and transcription today, faces a future where reports will be created using a hybrid blend of technology and service options, including dictation, transcription and EHR templates.

Provider Documentation is EHR's Biggest Challenge; Transcription's Greatest Strength

Transitioning providers from traditional dictation and transcription to electronic, template-based documentation is one of the greatest challenges for EHR implementation teams. Perhaps this is why there are less than 25 HIMSS Stage 7 (where all providers must document within the EHR) hospitals nationwide.

At URMC, computerized provider order entry (CPOE) and electronic nursing documentation were already implemented. Selection of the next generation EHR focused on patient-centric electronic, template-based provider documentation and the structured, discreet data that will result. The organization is starting with a difficult step for any organization – installing an EHR and the important point for medical transcription collaboration.

Because provider documentation is such a critical part of the EHR strategy, URMC decided to involve their transcription partner, ExecuScribe, early in the process. ExecuScribe representatives began attending EHR strategy meetings as early as 2009, and are still included in many provider documentation discussions. By involving their transcription vendor early in the EHR planning, URMC has already learned three important ways transcription companies can help. They are:

- ❖ Provider documentation experts with hundreds of standard templates are in place,
- ❖ Safeguards for quality documentation exist, and

- ❖ Technology specialists who bridge the gap from legacy dictation systems to new EHRs are available.

Three Reason to Get Your Transcription Company Involved

Transcription companies have been processing and managing provider documentation for decades. They have hundreds of report templates already in place and already know the finer nuances of each provider's documentation patterns and preferences.

By working together, HIM departments and transcription companies can achieve an important organizational goal – improve provider satisfaction as documentation moves from transcription to EHR templates, not abandon it. Specific strategies used by UPMC to maintain high levels of provider satisfaction include:

- ❖ Continually emphasize that the EHR is a clinical project supported by IT, not an IT project supported by clinicians.
- ❖ Involve clinicians in every step. They will be the ones using the record and must be the architects in designing how it will look in the future.
- ❖ Help them rethink documentation. For example, discharge summaries are no longer static documents to be completed and finalized. They are now a dynamic compilation of data generated throughout the entire care process.

Maintaining Documentation Quality in an Electronic World

ExecuScribe has served as UPMC's medical transcription and clinical documentation partner since 1998. Over the years, they have earned the reputation for continually exceeding expectations for quality, timeliness and customer support. In transitioning to an EHR, UPMC providers will expect the same quality and service levels. Expectations will remain high, and the need for complete accuracy and timely report turn-around doesn't go away in an electronic world. Paper, electronic – or both – this is still the legal medical record.

Furthermore, narrative reports will continue to be an integral part of healthcare and, as long as some narrative exists, the need for documentation safeguards will remain. UPMC will continue to rely on the experience and quality service provided by their transcription vendor throughout the transition.

Transcription Companies Serve as 'Plan B' When Legacy Systems Fail

The technology available through a transcription partnership also helps bridge the gap between legacy dictation systems and provider documentation within the EHR. For many hospitals, dictation systems are antiquated and maintenance fees are high. A solid transcription partner provides a reliable 'Plan B' for system downtimes.

In addition, other organizations that have implemented an EHR report declines in provider satisfaction when template-based documentation is installed. Industry experience shows that some providers will continue to want to dictate up to 30%, according to recent reports. Many have learned that 100% compliance with drop-down menus and templates may be unrealistic, despite the best-laid plans.

In these situations, transcription companies can provide speech technologies integrated within the EHR, along with medical editors to help bridge the gap. EHRs can be dictation-enabled as an alternative for change-resistant or time-constrained providers. If a busy orthopedic surgeon or cardiologist needs only two minutes to dictate a report, but six minutes to point and click, there will be challenges. During the time it takes to reduce the time difference in these functions and show the value add to codified data, transcription services can help fill the gap.

Clinician Involvement is Critical in Every Phase

UPMC has thought ahead when it comes to clinician challenges. They have emphasized clinician involvement throughout every step of EHR planning. It is a clinical project with information technology (IT) support; not the other way around.

Clinicians must steer the direction of 'what' the new medical record will look like as they will be the primary users of the 'new' medical record. Furthermore, clinician satisfaction is extremely important at UPMC. Medical records generated by an EHR look very different from their paper-based predecessors. It takes adjustment and the clinicians must be on board.

While the ultimate goal is to get every clinician – physicians, nurses and all ancillary services – to document within the EHR, the organization is taking it one step at a time. All nurses and ancillary departments that currently document electronically will convert to documentation within Epic, as part of Phase I, scheduled to go live in March 2011. Providers will also begin documenting progress notes, histories and physicals, consult notes, and discharge summaries within the EHR in Phase I. Operative reports will continue to be dictated in Phase I, with some EHR templates used for routine, standard procedures. There will still be places for free text, subjective input from providers within the discharge summary. However, the majority of the document will be created as a by-product of the data captured throughout the patient encounter. Structured data will then be used to evaluate care patterns and outcomes across patient populations within UPMC.

Final Thoughts and Words of Advice

For every piece of clinical documentation that will be created through the EHR, it is important to ask 'who' will be impacted by the change and begin the lines

of open communication and education. Transcription companies are the closest to provider documentation today, and have been for decades. It is crucial that they be included in your EHR planning and transition discussions, especially as it relates to provider documentation and satisfaction.

Finally, technology available through a transcription vendor should be in place to cover all the various 'what if?' scenarios. A solid back-up plan and transcription partnership eases the transition, while providing a reliable safety net for change.

Submitted by:

*Donna Barnard, MBA RHIA [RRHIMA] /
Linda Yaniszewski, President/CEO, ExecuScribe, Inc.*