Indian Health Service

Embracing Change in a New HIM Environment

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NORTHERN NAVAJO MEDICAL CENTER

Best practices from Navajo Area HIM after going paperless

REMINDER – Best Practices

The content of this presentation reflect the practices of the facility, approved locally by Service Unit management with consultation from clinical executive teams.

Think DIGITAL …not PAPER

NARA Mandate

- The National Archives Records Administration (NARA) informed all Government agencies that effective 12/31/22, the Federal Records Centers (FRC) will no longer accept any paper records for storage.
- The Government mandated all Government Agencies to digitize all records and files by 12/31/22.
- So what does this means for IHS medical records as no waiver was approved for IHS.

Digitize Medical Records

- To digitalize over 58,000+ medical records would cost Navajo Area over $6.5 million dollars for a contractor to complete for all Federal sites.
- This would take 3 years to complete.
- A lot of coordination between the vendor and HIM as many facilities are rural for access and supervision.
- No local lodging for contractor near remote sites.
- Contractor has to use RPMS VistA to transfer paper records to electronic.
- Paper record contains various paper materials that had have to be sorted and prepped for bulk scanning to be done by the contractor.
- Lack of workspace in HIM dept and facility for contractor to do work.
- Original medical records cannot be released to the vendor to complete work offsite.

Navajo Archiving Pilot Project

- In July 2020, Gallup Indian Medical Center HIM Dept. was ordered to move out of their area to make way for a new urgent care clinic. GIMC had to box up all their medical records for storage

- The same month, Navajo Area was granted by IHS HQ a temporary waiver, as a Pilot Project, to send all active paper medical records to the Federal Records Center for permanent storage for 5 Federal sites *(Chinle, Crownpoint, Gallup, Kayenta & Shiprock*).

- Over 14,212 boxes with 226,977 medical records sent to the Federal Records Center for 15 Federal Navajo Area facilities.

FUTURE of Health Records

- No more paper records and File Room

Going….

Going…

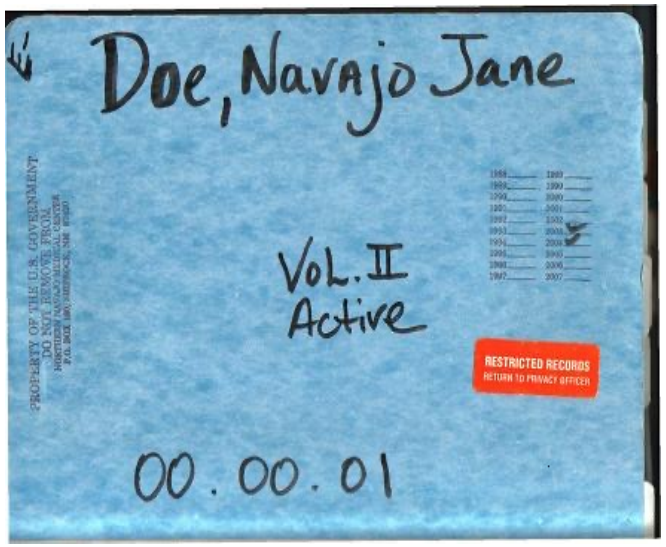
Going…

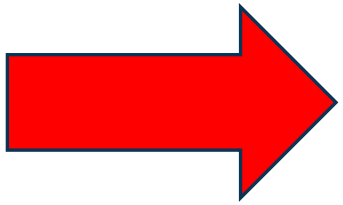
Gone!

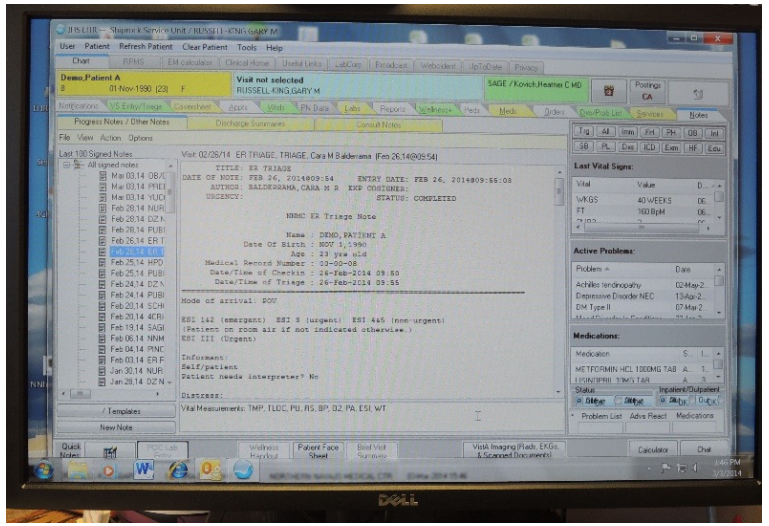
GIMC File Room

NNMC File Room

How do we convert paper processes?







WARNING! Scanning Tsunami

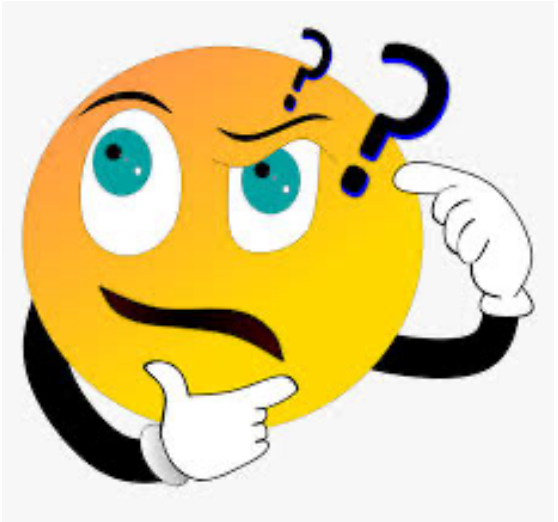
Anything and everything goes to HIM for scanning!

Special Areas To Consider

- Process for paper charting for Prenatal & Day Surgery
- Process for original sterilization consents
- Process for Nursing Units still using paper inpatient documents
- Prevent loss of paper documents
- Documents must be “scan ready”

HIM Scanning Questions

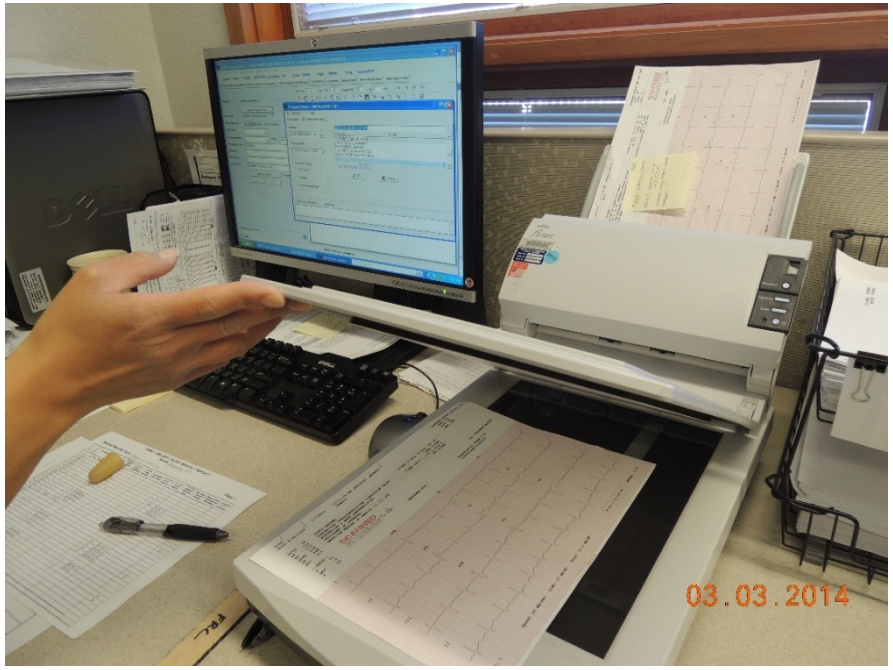
- Internal and external documents
- Priority scanning
- Quality check and retention
- Incoming PRC documents
- Chart note versus scanning document
- No designated provider, no chart, inactive record



Scanning of Documents

Identified two types of documents received for scanning:

- Internal
- External



Scanning of Documents

- **Internal** – Paper documents created by SRSU for the purpose of patient care which are originated by the facility.
- These original documents are scanned same day received.
- After quality check is completed at 100%, original documents are retained for 30 days, then destroyed.
- *Example:* Consent forms, inpatient nursing forms, blood transfusion forms, ER/Trauma forms, PCC forms. These are IHS, PHS, SF, HHS or SR form numbers.

Scanning of Documents

- **External** – Paper documents received from outside sources, other health care hospitals, IHS, Tribal, etc.
- Documents that are sent to medical staff office, PRC, clinic and case management by mail or fax.
- The documents do not belong to us, and are retrievable from the source if needed.
- If provider wants document scanned, document requires signature/date and date of note to scan into VistA.
- Quality check is done at 50% and document is immediately destroyed.

Priority Scanning

- HIM identified what documents need to be scanning immediately upon receipt:

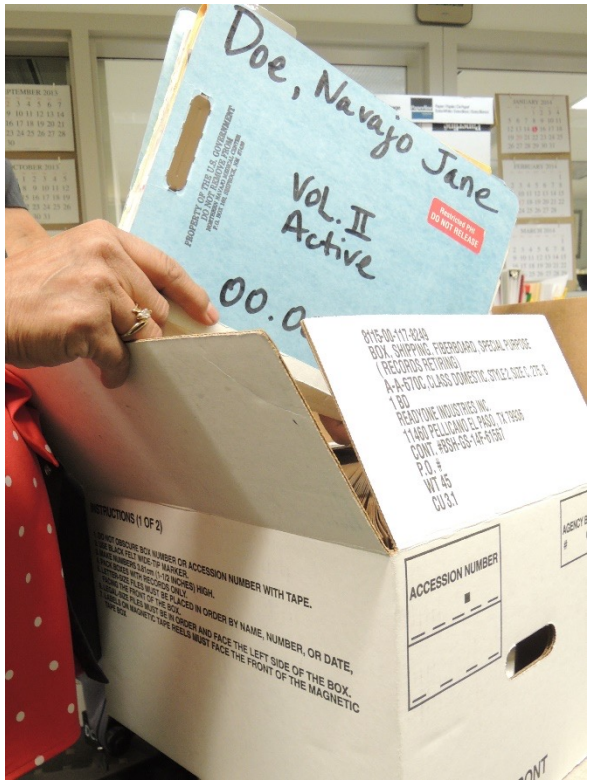
1. Paper consent forms for surgery, sterilization, etc.
2. Trauma Records
3. Emergency Room documents
4. Blood Transfusion Records

Scanning – Purchased Referred Care (PRC)

- On March 19, 2021, PRC no longer sent copies of patient records to HIM for scanning.
- These copies were outdated and were duplicates received from the medical provider or case management nurses for review and scanning.
- The copies sent to PRC remained with the PRC case file to validate obligation and payment of services in accordance to PRC guidelines.
- This new process reduced HIM scanning by 80%.

Scanning FRC Records

- The health care provider may need to review the original record for future health care treatment.
- The medical records is requested as a “temporary” removal from FRC to allow the record to be sent back after use.
- The entire medical record is NOT scanned into VistA upon receipt.
- Paper documents from the medical record maybe scanned into VistA at the health care providers request.



Scanning & Quality Check Backlog

Scanning Shelf to be done
As of 3/1/22 = 31,970 documents to be scanned

COVID scanning (checklist/consents)
29,095 to be scanned

Quality Check to be done
190,846 pending

Patient Paperwork Task Force

- Group established July 20, 2022 to address the coordination and elimination of duplicate copies of medical records received within the facility. The group membership consisted of HIM, clinical chairs, case managers and radiology.
- The following slides are recommendations from this group that has helped reduce the incoming patient flow.

To Scan or Not to Scan

- Healthcare Provider can abstract health information from the correspondence into a E.H.R. note as a chart review:

  Example: *"Received discharge summary from UNM Hospital. Patient admitted for COVID-19 for 12 days. Patient recovered and doing well"*

  "Test results received from San Juan Oncology on 03/01/22. Patient has ovarian cancer stage 1. Chemo treatment to begin April"

- The document can be destroyed after a note has been entered with the pertinent health information by the provider as the document does not need to be scanned.

Inactive or No Patient Record

- What to do with documents received that…
  1. Have no designated provider
  2. Are inactive after 3 years
  3. Do not have a chart established

- HIM to :
  1. Return documents to sender
  2. Destroy if inactive or no chart established

Recording a Disclosure

- If disclosing copies of EHR notes for continuity of care under HIPAA/Privacy Act provisions, the health care provider can document by doing a chart review, quick note or addendum note to record this:

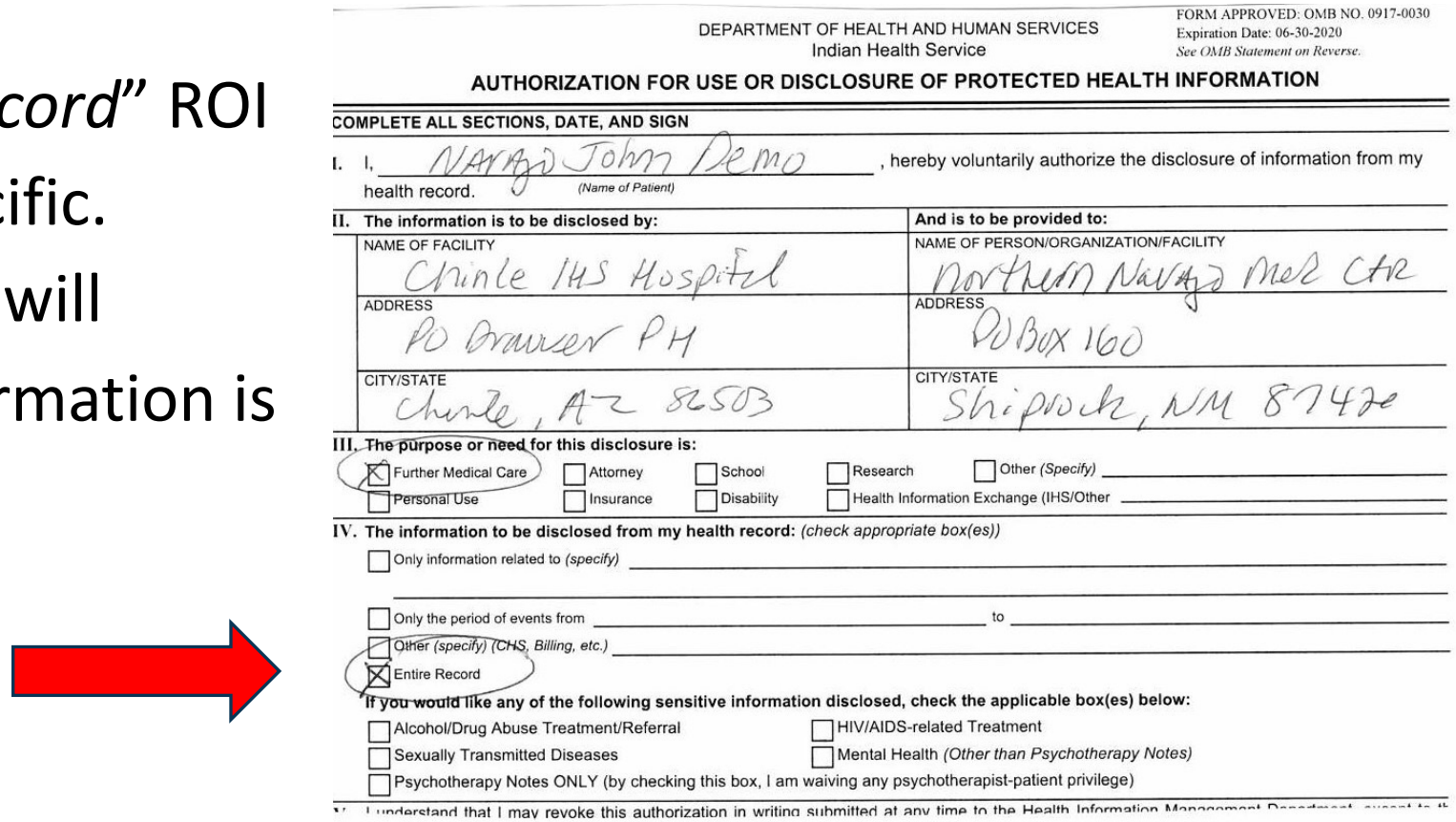
  Example: "*Copy of EHR note disclosed to UNM hospital*"
  "On 3/1/22 EHR notes from 01/03/22 sent to Dr. King at Lovelace Hospital"
- Mandated that all ROI inquiries by fax, phone and in-person be sent to the HIM ROI Office. This allowed HIM ROI to record for accounting of disclosure in the RPMS ROI Package.

Scanning – Case Management

- The Case Manager Nurse assigned to the clinics assist with reviewing all incoming documents for the health care provider and determine if the information is needed for continuity of care.
- The case manager would do a chart review note summarizing the health information and send to the health care provider as a Co-signer. The paper document is then destroyed.

Challenges

- Reduce all "*Entire Record*" ROI requests and be specific.
- Health care provider will determine what information is needed



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 06-30-2020
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, Navajo John Demo (Name of Patient), hereby voluntarily authorize the disclosure of information from my health record.

II. The information is to be disclosed by:	And is to be provided to:
NAME OF FACILITY: Chinle IHS Hospital	NAME OF PERSON/ORGANIZATION/FACILITY: Northern Navajo Med Ctr
ADDRESS: PO Drawer PH	ADDRESS: PO Box 160
CITY/STATE: Chinle, AZ 86503	CITY/STATE: Shiprock, NM 87420

III. **The purpose or need for this disclosure is:**

☒ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____
☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (IHS/Other _____

IV. **The information to be disclosed from my health record:** *(check appropriate box(es))*

☐ Only information related to *(specify)* _____
☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☒ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to th

Electronic Disclosure – Release of Information

- Goal is to stop printing and copying paper.
- NNMC HIM ROI office used Secure Data Transfer (SDT) to release records to patients, attorneys and other requesters that have a email address.
- This allowed quick response to the request.
- Requesters are reminded to access SDT within 14 days to print or save disclosed documents.

Electronic Disclosure – Release of Information

- RPMS DIRECT Messaging is used for internal disclosure of PHI within IHS and Tribal sites that are running RPMS applications.
- Separate RPMS DIRECT email addresses created for all sites for HIM and ROI.
- Secure Web Portal allows ROI to download E.H.R. records via PDF to requestor(s) such as CDAC.

Challenges

- Not all Service Units onboard with new technology:
  - Other SU staff not trained on Secure Data Transfer
  - No disc reader on desktop PCs for providers to view
  - No training on RPMS DIRECT messaging to SU staff

Scanning – Success

- HIM scanning is same day.
- VistA imaging is not clogged up with duplicate documents and/or documents not needed for patient care.
- Streamlining communication for patient care.

Health Information Exchange (HIE)

- Healthcare providers are able to view patient health information through the Health Information Exchange web portal.
- Healthcare team can do a quick chart review note in EHR to record pertinent health information.
- HIE agreements with: UNM, SJRMC, Presbyterian, Flagstaff Medical Center, Lovelace and Banner Hospital in Phoenix.
- No more sending paper medical records to scan.

Health Information Exchange (HIE)

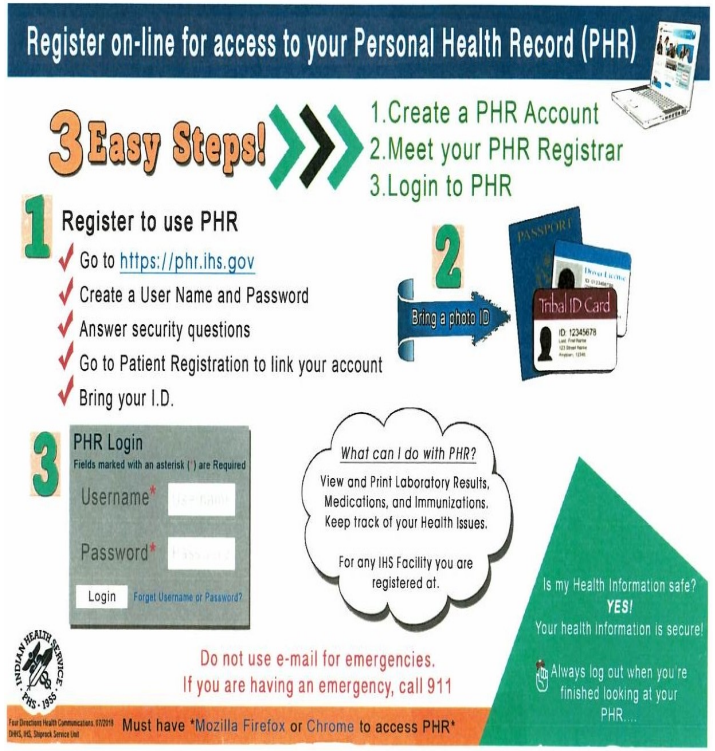
- IHS 4 Direction Web Portal – *Pending*
- Will allow health care teams to access and view any IHS medical record nationwide.
- Reduce the need to request copies of medical records from local hospitals patient are referred to.

Transition of Care (TOC)

- Transition of Care agreements with local/State hospitals, to allow summaries to be automatically downloaded to EHR daily.
- Emergency Department and inpatient discharge summary from two contract hospitals are available for health care team.
- HIM EHR Tech coordinates daily.

Personal Health Record (PHR)

- Promote patient enrollment for Personal Health Record (PHR) at your sites.
- Patients will have immediate access to pertinent health information.
- Create enrollment drives to get the education out and make it easy for patients to enroll.



Personal Health Record (PHR)

- Recruit other departments to participate with PHR enrollment:
  - PRC = Excellent tool for patients being referred out for care to outside health care facilities.
  - Prenatal Clinic = For those prenatal patients who deliver somewhere else.
  - Local Dialysis Units, High School seniors, and Armed Forces Recruitment Centers that serve Native people.

Digital HIM Changes

Identify other HIM areas that will be impacted by change.

Master Control Log

- If your site is maintaining a Master Control Log, it will be very important to establish a communication process between the clinic MSAs and Patient Registration to ensure that inactive patients are reactivated accordingly.
- Keep your Master Control Log simple.

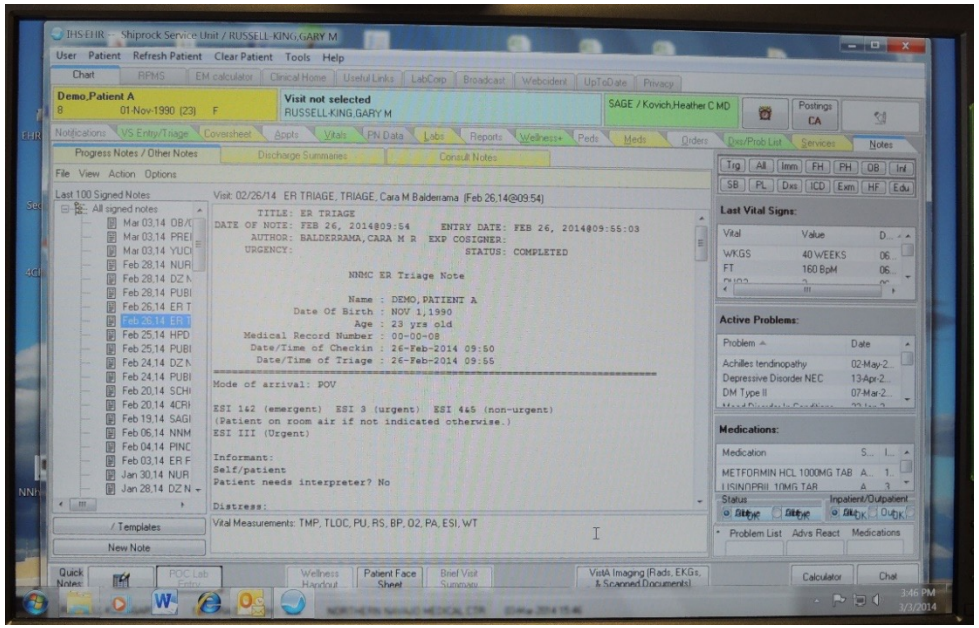
Number	Patient's Name	Active	EHR	Expired	FRC	Destroyed
00 00 00						
01 00 00						
02 00 00						

Electronic Analyzing

- Going EHR did not replace the requirement to analyze patient documentation.
- Electronic Signature need to be check for legal name and credential.
- Correct EHR template used.

Electronic Analyzing

- EHR notes need to be reviewed for
  - Inappropriate charting
  - Redactions
  - Cut-n-Paste
  - Cloning
  - Coding specificity



Duplicate Records

- HIM should have a Standard Operation Procedure (SOP) to handle duplicate medical records due to issuance of John Doe, Trauma and multiple records established in RPMS.
- Only HIM should be handling this process as HIM is responsible for the legal record.

Duplicate Records

- The SOP should cover:
  - Which Health Record Number to use.
  - How to move EHR notes, using cut-n-paste and re-sign or administratively close if provider no longer here.
  - Printing up EHR orders, consultants, lab results to scan into the note.

John Doe - Admission

- Once the patient is identified, and has a HRN on file, the following needs to occur in the correct HRN:
  1. Admission Office admits patient in ADT.
  2. Admitting doctor writes admission order.
  3. Admission order serves as the anchor note to move all EHR notes under using cut-n-paste. All notes are resigned for completion.

Adoption

- Develop similar SOP for Adoption process:
  - Identify if newborn or older child.
  - Are records all electronic or paper.
  - Use cut-n-paste to edit notes containing any reference to biological parents.
- REMEMBER – Timeliness is critical to amend and correct record.

Administrative Closure

- Create EHR template to close out medical records due to:
  - Incomplete records
  - Incomplete consents
  - Duplicate and adoption records
- Only the HIM Director should electronically sign these notes, with the designated Physician Liaison from the HIM Committee.

Administrative Closure – Incomplete

HIM Administrative Closure
Shiprock Service Unit

DEMO,PATIENT A HRCN:00-00-08

Date of Procedure:
Date of Admission:
Date of Visit:

This medical record was sent to the HIM/Medical Records Committee for administrative closure; the medical provider indicated is no longer employed by this facility and cannot complete the documentation.

The following areas were found to be incomplete:

The above medical record was approved for Administrative Closure by the HIM/Medical Records Committee and deemed complete to be returned to permanent file.

Sample

DEPARTMENT OF HEALTH & HUMAN SERVICES INDIAN HEALTH SERVICE

Northern Navajo Medical Center
Health Information Management
P.O. Box 160, U.S. Hwy. 491 North
Shiprock, New Mexico
87420
Office: 505-368-6032 Fax: 505-368-6277

8/1/2023

For The Record:
RE: Administrative Closure

The attached listing of patient records is being presented on behalf the HIM Committee to be approved for administrative closure in the RPMS Electronic Health Record system, as these records are incomplete and cannot be completed by the designated individual for the following reasons:

- Provider no longer working at Northern Navajo Medical Center and has Incomplete/Unsigned/Un-cosigned Progress Notes.
- Incomplete consent forms.

Total number of patient records: 2

I approve HIM to administratively close these patient records, in accordance to the HIM Committee policy and procedures.

CONCURRED:

_____
Gary M. Russell-King, HIM Chief
Northern Navajo Medical Center

_____
Jean E. Howe, M.D.
Chief of Staff

DOS	HRN	REASON FOR ADMINISTRATIVE CLOSURE	PROVIDER	SERVICE	DATE OF ADMIN CLOSURE CREATED
7/10/2023		No inpatient consent form	Pt Registration	Business Ofc	7/11/202
7/14/2023		No Physical Therapy progress note	M allahan, PT	Physical Ther.	7/14/202

Administrative Closure - Duplicate

LOCAL TITLE: CHART REVIEW
DATE OF NOTE: JUL 25, 2023@15:05 ENTRY DATE: JUL 25, 2023@15:06:03
AUTHOR: RUSSELL-KING,GARY M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

HIM Administrative Closure
Shiprock Service Unit

DEMO,PATIENT C HRCN:00-00-10

Date of Visit: 6/30/2023

Due to duplicate patient registration error on 04/10/1985, this visit has been moved from HRN #01-01-01 to the correct HRN #01-01-02 for continuity of care. HRN #01-01-01 has been inactivated.

This transaction approved by the HIM chief.

/es/ Gary M. Russell-King
Chief Medical Records Administrator
Signed: 07/25/2023 15:53

Accepting Change In HIM

"Why do we have to do this?" "I hate change"

- Health care changes due to advancement in medicine.
- You have to be adaptable to change working in HIM.
- Change is all around us and we each experience change in our daily lives.

HIM Staffing Changes – Old Days

File Room duties gone…

HIM Staffing Changes

- The need for other HIM positions:
  - Scanners
  - EHR Informatics
  - Clinical Documentation Specialist
  - Full-Time Privacy Liaison
  - Coding Auditors
  - PHR Registrars
  - Data Transcribers
  - More Coders
- Reduction of HIM staffing level.

  Example: *NNMC File Room staff reduced from 18 staff members to 6*.

HIM Changes

- Hours of Operation – 24/7 coverage no longer needed after going paperless. No more after-hour, weekend, and holiday shifts.
- Some HIM functions and processes going away due to technology.
- All HIM staff (except coders) moved to one MRT job description that includes all HIM functions. No more specialization.
- Telework – Coders working from home.
- Dual functions of analyzing & coding.
- Concurrent chart analysis on Inpatient Units.

The patient ALWAYS comes FIRST!

Everything that HIM does touches patient care & treatment

Questions

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Email: gary.russell-king@ihs.gov


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