

The College of St. Scholastica  
Duluth, Minnesota

Tools for Training and Retaining  
Quality Health Information Management Employees

By

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Approved: July 19, 2013

Submitted in partial fulfillment of the requirements for the degree of Master of Science in Health Information Management, The College of St. Scholastica, Duluth, Minnesota.

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### **Acknowledgements**

My deepest appreciation goes to my preceptor, Lynette Caldwell, for her great support; I truly want to thank her for the time and effort she dedicated to the benefit of this project. I extend my sincere gratitude to Lynne Stanton for her guidance which pushed me forward and made it one of my best learning experiences. Also, a huge thank you goes out to Janelle Wapola, my second reader. Your, time, expertise, and constructive criticism are greatly appreciated.

I would also like to thank Ron Cluck and Billie Fear for their valued contributions of time and explanation. I would like to especially thank my husband, Warren, who understandably shared me with my final project and also provided encouraging and unwavering support in all my studies. And last, but not least, I thank Pamela Oachs for her insightful reviews, flexible response times, and keen eye in steering me straight ahead.

### **Abstract**

The training and retaining of quality employees is an essential element of a Health Information Management (HIM) department. There is a need for a personalized approach to project team training and ongoing individualized training in order to drive initial and continual adoption and adaptation of an ever improving EMR within the HIM department. Although HIM, as a profession, has a rich history of effective change; the HIM department at Great Plains Regional Medical Center (GPRMC) was lagging behind when the facility began applying Meaningful Use initiatives. This project offers a plan to effectively equip HIM employees with solid, informal, on-the-job training following the guidance of formal literature research. Training is pivotal to ensuring that employees possess the knowledge necessary to effectively carry out their job duties. Because employers know of this importance, they seek candidates who are educated and plan on training them towards their organization's policies and procedures in order to ensure that their employees remain up-to-date. The basic training plan developed focuses on the proper scanning techniques for various documents, analysis of these documents for thoroughness and completion, and finally, the proper steps toward the release of information.

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## Chapter One: Problem Statement

Great Plains Regional Medical Center (GPRMC) is a regionally located, 120-bed hospital system comprised of acute care, a Level 3 Trauma Center, a cardiology interventional unit, a behavioral health care unit, and a cancer center. The hospital covers an approximate 150-mile radius North from the South Dakota state line; South to the Kansas state line; West to Sidney, Nebraska; and East to Grand Island, Nebraska. Due to the increasing need for rural specialized services, the hospital system is rapidly expanding their hybrid electronic medical record (EMR) capabilities in attempts to keep current with meaningful use (MU) requirements.

GPRMC's hybrid medical record is comprised of approximately 40% COLD feed, 35% scanned paper documents, and 25% HL7 interfaced documentation. The time required for prepping, scanning, and indexing paper documents into the EMR is 24 hours from when the patient is discharged.

A legacy software system is being utilized since a true workflow module has yet to be incorporated. Currently, a hybrid system sees the patient visit initiated with a silo Admission Discharge Transfer (ADT) software system. This is used to register the patient with a medical record unit number (MRUN) and a simultaneous account visit number.

The technical staff is comprised of five members. This project became pivotal when one technician announced her approaching retirement and another was out on an unexpected long term medical leave. Within a month's span, a third technician accepted a coding position with an outside clinic. Two to three new technicians required simultaneous training in the various aspects of health information management (HIM) job responsibilities.

The HIM director is looking to the HIM manager to discover a way to improve employee retention and job satisfaction while also reviewing the present policies and procedures to develop

an instructional training application using standard guidelines for EMR completion and data management. Currently, the EMR completion process is a labor intensive, tedious manual process arising in multiple human errors. This is quite possibly due to the latitude allowed for personal preference in task accomplishment and completion. Within the past six months, rapid changes have occurred within GPRMC's HIM department. Through better communication, job stress could be reduced; career enhancement with an opportunity for upward mobility can be addressed; and the shortage of funding for reference books, education, and training could be overcome. The time is now to accept the technological challenge and establish a well-documented training manual that correlates to the organization's vision, mission statement, and goals of quality patient care.

A tentative solution involves an understanding by HIM leadership of the need for a semi-structured training process. It will take considerable contribution on their part to adequately influence and shape the educational and professional experience of their employees. The HIM director has requested a training manual which establishes a standard guideline for the design and implementation of a properly processed EMR. Correct processing will involve all the technicians in a cross-training approach. Resolving this processing issue at GPRMC will help to provide better patient care at the back end support level or rephrasing, at the non-clinical documentation level. Development and design of a standardized training process, complete with an instructional training manual, will be initiated. Through the utilization of process improvement, these tools will enable the HIM department to meet the required 24 hour turnaround time thus maintaining the continued computer assisted documentation review which should also be advantageous at the physician satisfaction level. With the evolution of the EMR,



these tools will enable the medical records department to meet and fulfill the current industry standards currently in the field of HIM.

## Chapter Two: Literature Review

The transition to an electronic medical record (EMR) is different for every facility and completing the process successfully depends on many factors. It all starts with evaluating the facility's existing IT systems and planning for full integration and interoperability of those components.

The healthcare reform provisions within the American Reinvestment and Recovery Act (ARRA) and the Patient Protection and Affordable Care Act (PPACA) are providing the regulatory requirements and funding to significantly increase the amount and type of healthcare data available for analysis. The ultimate goal of these acts is to improve access, patient safety, outcomes, and efficiency of the healthcare system (American Health Information Management Association [AHIMA], 2008).

Part of the force for change lies in the fact that it has been identified that while the United States leads the world in the development of new approaches to cure, diagnose, prevent, and thus manage illness to improve healthcare, these improvements are not reaching all of the people who could benefit from them (Agency for Healthcare Research and Quality [AHRQ], 2012).

America spends more on healthcare than any other country in the world. A great number of Americans make the assumption that this means we have the best healthcare system in the world. American's have the tendency to believe you get what you pay for and we pay more on an individual basis than any other nations' citizenship. In truth, the American healthcare system ranks 37<sup>th</sup> among all developed nations and is actually falling further behind every year (Murray, Phil, & Frenk, 2010).

## History of Health Information Management

In 1928, the Association of Record Librarians of North America was organized under the sponsorship of the American College of Surgeons. Originally, the profession was referred to as medical record science, and professional members were addressed as medical record librarians. From inception, the profession's mission has been to bring to the forefront the standards of clinical recordkeeping in providers' clinics, hospitals, and other healthcare facilities. The professional association, now known as the American Health Information Management Association (AHIMA), and her professional affiliates have been advocates for the effective management of clinical records to ensure their accuracy, confidentiality, and accessibility in every type of healthcare setting (LaTour & Eichenwald Maki, 2010).

In 2000, AHIMA's Committee on Professional Development completed the most recent update of the professional definition for health information management (HIM). The new definition reads:

Health information management improves the quality of healthcare by ensuring that the best information is available to make any healthcare decision. Health information management professionals manage healthcare data and information resources. The profession encompasses services in planning, collecting, aggregating, analyzing, and disseminating individual patient and aggregate clinical data. It serves the healthcare industry including: patient care organizations, payers, research and policy agencies and other healthcare related industries (Russell, 2001, para 4).

One of the areas of professional concern for AHIMA is the use of standards.

## **Standardization**

Standardized work means that methods have been established after careful consideration from all potential angles and thought processes. These methods are the most efficient and productive means possible to complete the tasks, regardless of the level of employee. Work standards usually consist of the aim of the work, constraints on carrying out the work, and the means and methods to be employed in carrying out the work (Kondo, 2000). Hall and Johnson (2009) explain that in order to become standardized, a process should be able to reduce the task to a science. If the processes get to the point that failure is rare, it has become predictable and can be a science.

The matter of standards for the EMR is prompting heated debate in recent meetings of medical representatives due to the fact that it is an issue that potentially affects the health and safety of every American. The controversy points to the delicate balance of interests involved when creating technical standards that inherently limit design choices while trying to keep the door open to innovation. At issue is the Obama administration's plan to develop standards to measure how effective and easy digital patient records are to use. They are doing this by applying a research discipline known as human-computer interaction or human factors. The International Organization for Standardization (ISO) defines the usability of a product by three attributes: effectiveness, efficiency, and satisfaction (National Institute of Standards and Technology [NIST], 2010).

Both the Agency for Healthcare Research and Quality (AHRQ) and the National Institute of Standards and Technology (NIST) are exploring, in detail, the issue of EMR adoption and usability rates. According to the NIST, without usable systems; doctors, nurses, staff, and consumers will not be able to gain the potential benefits of the functions and features of EMR

systems (Schumacher, 2010). Similarly, according to the AHRQ report, the EHR drives the market toward the creation of usable products. Through the development of process improvement, recognition is gained requiring that an organization's processes accurately identify usable products, establishes and disseminates standards, and encourages innovation (AHRQ, 2010).

### **Change Management**

In order to implement standardization, there must be change. According to Erwin (2009), there are four phases of change. The first phase is simply realizing the need for change. The need is most often inspired through financial necessity. Once this first phase has been recognized and accepted, the second step is required. The second phase is planning for change. This step establishes the goals and objectives. A plan is designed which will enable the accomplishment of the defined goals and objectives. The third phase is taking the plan and actually implementing the change by putting the change process into motion. This phase is the most challenging portion of the project. People typically resist change because they fear the unknown. New ideas and concepts are more readily embraced when staff understands the rationale behind and the benefits of making these changes (Erwin, 2009). The final phase is to evolve and maintain the goals and objectives until they are reached.... then re-evaluate the goals and objectives as the process progresses.

According to Matteson & Ivancevich (1987), change in the workplace can lead to job stress. Stress tends to occur when the requirements of a job do not match the abilities, resources, and/or needs of an employee. Long-term, chronic exposure to job-related stress may result in organizational inefficiency, decreased practical competency, and reduced job satisfaction (Matteson & Ivancevich, 1987). When a change in operation is first introduced,

employees/people tend to balk. Most resistance to change usually comes from employees who have repetitive, routine, everyday-type processing tasks. Employees are more willing to accept new ideas when they understand the rationale and benefits in making the changes (Edosomwan, 2009). Engaging employees in conversation regarding the daily operations should give the change effort a higher profile.

Those resistant to change often need to see others actually processing their workload in a different manner before they are comfortable in changing their own workload process. To assist employees in the transition process, each staff member needs to be comfortable with the tasks they will be performing (American Medical Association [AMA], 2012). Employees cannot be forced to change; however, desired behaviors can be consistently modeled. Employees should be praised when they successfully demonstrate the desired behaviors (Yeung, 2009).

Project leadership encompasses two distinct roles: that of a project manager who has skills and experience in managing complex project implementations and that of a project champion who has organization credibility with his/her peers (AMA, 2012). By having both powerful and positive influences present, this is how you 'sell' change to current staff.

Getting the whole team on board is key to success. IT-related projects, no matter the industry, have a high failure rate that is largely due to poor change management. Remember, an EMR system will likely change the roles and duties for every technician, which, in turn, can lead to fear and anxiety, as mentioned previously. Change of this magnitude changes the culture of the organization. It is imperative for the project champion to address staff concerns openly. All staff must feel his/her feedback is important and that the change is in the best interest of the organization and its patients (AMA, 2012).

### **Management Direction**

Managing employees, especially in times of change, requires recognizing and meeting the needs of the employees as well as those of the organization. Healthcare organizations must provide employees the tools for career success and personal achievement if they are to win their long-term commitment (LaTour & Eichenwald Maki, 2010).

At the helm of any HIM department should be an educated, credentialed, and dedicated director who embraces the ever-changing environment of the profession. According to Henry Fayol, there are three categories of managerial skills required in order to effectively manage people. As simply defined by LaTour and Eichenwald Maki (2010), skills include:

1. Conceptual – the ability to understand diverse fields and deal with complex situations;
2. Interpersonal – the ability to work with and through others to accomplish goals; and
3. Technical – understanding and mastering the technical information, methods, and equipment involved in a disciplined change.

The accomplishments of effective management should be evident through the performance and overall success of the employees. However, in order for management to be considered successful, it must also attain the goals and objectives of the facility (Rane, 2007).

Healthcare managers are finding that managing technology and data along with managing employees is critical to meeting an organization's goals. The adoption of technology is essential for the success in balancing quality demands with the needs of both the physicians and the patients. Quality programs are highly data driven and the accuracy of what is being reported to the public strongly depends on the ability to collect the correct data in a timely manner. Data

inconsistencies and errors lead to lost opportunities and mistakes, causing stress for employees and managers who make these errors based on poor quality data (Turban & Volonino, 2009).

Data can be very challenging to manage and track. Searching for, retrieving, and managing data located throughout an organization is a major challenge for numerous reasons. An imposing fact leading this list of reasons is that the volume of data available increases immensely over time. In addition, the problem is that much of the data quickly becomes irrelevant and must be sifted out before the useful data may be worked (Turban & Volonino, 2009).

Healthcare organizations understand and fully appreciate the serious need for managing, controlling, and understanding data. It is one of their most important assets (AHIMA, 2012). The data derived from administrative, billing, clinical and demographic record management enables the important decision making required for the best quality of patient care.

### **Employee Development**

An employee's knowledge and ability to perform his/her duties are vital to meeting organizational goals as well as productivity goals for both the individual and the department. Formal training accounts for less than 20 percent of what employees learn while on the job. Informal learning takes place without an instructor. Informal learning is not recognized as formal training; in fact, the employee determines how much they are taught and when they are trained. The concept behind informal learning is that the employee seeks out the knowledge in the belief or understanding of what they do not know and understand and need to learn (Nancherla, 2009). According to Nancherla (2009), informal learning has low cost with a great amount of impact and is very beneficial for both the employee and the organization.



Another method used to involve employees is a one-on-one involvement between the employee and a coach. Coaching focuses on job-related issues dealing with new job transitions. Emphasis is placed on building the employee's ability to deal with these issues by using his/her own decision making skills versus instruction outlining specific actions to undertake (Goodge & Coomber, 2010). Coaching has also been defined as continuous, face-to-face influencing of an employee to increase the employee's skill to perform and to gain knowledgeable understanding of a job's entirety (College of Health Information Management Executives [CHIME], 2012). Coaching is a facilitation of learning. It is a management culture based on involvement, inclusion, and participation of the coach and the employee. By focusing on the behaviors that assist in employee empowerment, learning, and development; the employee's strengths are emphasized. Coaching is seen as an essential element of effective management (CHIME, 2012).

The underlying principle of coaching is self-directed learning. Coaching managers look at what people are rather than what they are not. They build on employees' strengths and look for the best in their personnel. Here mistakes are seen as learning opportunities and employees are given space and encouragement to learn how to get the most from their personal capabilities and skills (Health Information Management Systems Society [HIMSS], 2012).

Great coaching relationships are based upon appreciation and accountability. Appreciation is when an effective coach is skilled at recognizing the natural talents of others and promoting them. Accountability is holding personnel to their own standards, not that of the coach (Thompson, 2008). The coach is responsible only for coaching activities that are based on specific, measurable goals (CHIME, 2012).

There are two types of coaching approaches, individual and team. The expectations are laid out and the goals are clearly defined in team coaching. All those involved understand that

unacceptable behavior will not be tolerated and everyone must contribute. Individual coaching is demonstrated when the coach informs the junior individual of what he/she must do to become more effective, to refrain from doing what is ineffective, and to continue doing what is working (Field, 2007).

Of notable consequence, according to Rosen (2009), is that not everyone is coachable. Time, effort, and money should not be wasted on employees who are able to do the job however do not have the self motivation to do it well. An assessment will aid in determining whether or not an employee has potential. An underperforming individual involves too much time and money to externally motivate in order to perform at the level required for them to be successful. Coaching decisions are to be based on win-win-win for the organization, the employee, and the coach. Coaching decisions are not to be based on emotions, hopes, or unrealistic expectations. Personnel should not be hired based on their potential but rather on their proven past achievements (Rosen, 2009).

Mentoring is another method used to promote employee performance improvement. It is a relationship between two individuals in which the more experienced team member agrees to support the development of the less experienced counterpart. Mentoring is usually a formal or informal relationship between two people; a senior mentor (usually outside the protégé's chain of supervision) and a junior protégé. Mentoring has been identified as an important influence in professional development in both the public and private sector. The war for talent is creating challenges within organizations not only to recruit new talent, but to retain talent. Benefits of mentoring include increased employee performance, retention, commitment to the organization, and knowledge sharing (US Office of Personnel Management [OPM], 2008).

Listed below are some of the effective and proven practices used in implementing a mentoring program according to OPM (2008):

- Develop a recruitment and marketing strategy
- Match mentors and protégés
- Conduct an orientation program
- Develop instruction guides for mentors, protégés, and supervisors
- Develop a mentoring agreement
- Develop a mentoring action plan
- Provide a list of topics to discuss
- Provide developmental activities
- Conduct an evaluation.

At times it becomes relevant to involve the whole team in process improvement. Large group methods (LGMs) are comprised when all of the stakeholders are gathered together to address the situation (Ulrich, Kerr, & Ashkenas, 2002). The Work-Out method has the premise of understanding that the employees know more than management when something goes wrong. The employees know how to improve or fix what went wrong. According to Alban & Bunker (2009), another type of LGM is the Conference Model. This is where the employees analyze the work process, identify where the errors took place, and aid in redesigning the process to work more efficiently. Both LGMs make it possible for the employees to apply their ownership in troubleshooting to correct the problem(s). They become part of the solution and thus have an acknowledged voice.

## Learning Styles

According to the National Highway Institute (NHI) (2012), there are three primary learning styles for adults. They are: visual, auditory, and kinesthetic.

**Visual learners.** Visual learners tend to learn by looking, seeing, viewing, and watching. Visual learners need to see an instructor's facial expressions and body language to fully understand the content of a lesson. They tend to sit at the front of the classroom to avoid visual distractions. They tend to think in pictures and learn best from visual displays. During a lecture or discussion, they tend to take detailed notes to absorb information (NHI, 2012).

**Auditory learners.** Auditory learners tend to learn by listening, hearing, and speaking. Auditory learners learn best through lectures, discussions, and brainstorming. They interpret the underlying meaning of speech by listening to voice tone, pitch, speed, and other speech nuances. Written information has little meaning to them until they hear it. They benefit best by reading text out loud and using a tape recorder (NHI, 2012).

**Kinesthetic learners.** Kinesthetic learners tend to learn by experiencing, moving, and doing. Kinesthetic learners learn best through a hands-on approach and actively exploring the physical world around them. They have difficulty sitting still for long periods of time and easily become distracted by their need for activity and exploration (NHI, 2012).

Learners retain approximately 10 percent of what they see; 30 to 40 percent of what they see *and* hear; and 90 percent of what they see, hear, *and* do. (Dale, 2008). An individual has the capability to learn via all three styles, but are usually dominant in one. Table 1 shows some of the methods that appeal to visual, auditory, and kinesthetic learners. Training should take into account all three styles.

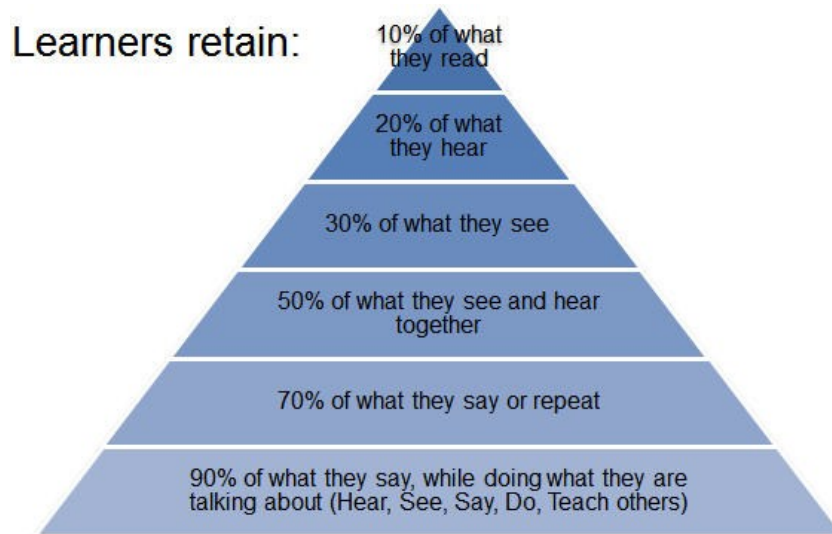
Table 1

*Styles of Learning*

<u>VISUAL</u>	<u>AUDITORY</u>	<u>KINESTHETIC</u>
Transparencies	Lectures	Role plays
Videos	Slides Group discussions	Simulations
Flip charts	Informal conversations	Practice demonstrations
Readings	Stories and examples	Writing/Note taking
Demonstrations	Brainstorms	Activities

(Russell, 2012)

Learners will retain 10% of what they read; 20% of what they hear; 30% of what they see; 50% of what they see and hear together; 70% of what they say or repeat; and 90% of what they say while doing what they are talking about. Hear, see, say, do, and teach others (Dale, 2008). See Figure 1.

*Figure 1 Dale's Cone of Learning*

(Dale, 2008)

### Training Program Development

Training programs play a vital role in the strategic management of healthcare organizations. To remain financially viable, healthcare organizations must emphasize productivity, performance, and profitability (LaTour & Eichenwald Maki, 2010).

When developing productivity expectations for any function, it is imperative that the processes be evaluated thoroughly. Organizations should not assume that published productivity standards are firmly set and should be adopted without some evaluation and tweaking. Every facility has its own conventional behavior and must accordingly develop its own productivity expectations. Expectations should be realistic yet require some stretching to reach the goal (Dunn, 2007). Many factors affect productivity. Programs differ, functions are affected by a

host of factors, and equipment variations have a tremendous impact on throughput. However, some observed averages for each step in the scanning process are possible for general reference only. See Table 2 for a sample of productivity goals.

Table 2

*General Productivity Expectations*

<b>Function</b>	<b>Expectations per Worked Hour</b>	<b>Factors Affecting Production</b>
Prepping	340–500 images	Tears, staples, lack of patient identification on each page, assembled or not
Scanning	1,200–2,400 images	Speed of scanner; age of scanner; scanner maintenance; size of batches
Quality Control	1,700–2,000 images	Lack of attention to detail by the prepping and indexing staff; size of viewing screen
Indexing	720–800 images	Presence of bar codes on forms; presence of bar-coded patient labels

(Dunn, 2007)

**Staff Orientation**

Input from the Human Resource department and from the HIM department supervisor is a strong factor for consideration when developing an orientation program. To develop an



orientation program, it is beneficial to begin with a task analysis. The job description and the job specification are excellent sources for this part of the process (LaTour & Eichenwald Maki, 2010). In addition to specific tasks, all new employees need a solid understanding of benefits, personnel policies, and safety regulations. Accreditation organizations, the Federal government and state specific regulations also require the inclusion of detailed topics in the orientation of new employees (Dunn, 2007).

The design of an effective checklist will serve as an efficient orientation guide. The checklist serves both as an agenda for presenting the material in a logistical sequence, and also it assures the employer that the employee is receiving the proper information. The next step is to construct an employee handbook. By compiling present policies and requirements that all employees must know into an employee handbook, a handy reference tool remains after the orientation period has ended (LaTour & Eichenwald Maki, 2010). As the new employee is trained, the supervisor should document his/her demonstrated competency.

Overall, the quality of work performed is more important than quantity of work performed. Quick work is of no value if scanned images are crooked or torn, if documents for one patient appear in another patient's account, or if the wrong account visit number was assigned to an entire EMR chart. If low-quality images end up in the system, clinicians will be unhappy with the HIM technician and the HIM department, in general. Most notably, the lack of readable documentation will adversely affect patient care and accreditation compliance.

### **Coming Full Circle**

Once there is competent, qualified staff firmly established within the HIM department, our transition to an interoperable EMR should more readily take hold. The required skill sets for health information management and exchange specialists is a recognized shortfall in the



workforce (AHIMA, 2012). Qualified staff, proficient in critical thinking and technical skill application, will enable our organization to succeed. As the use of secondary data begins to take hold, data integration and analysis will evolve (AHIMA, 2012). HIM employees need to be at the forefront.

With the ability to utilize EMRs for patient care and data mining, the Medicare and Medicaid EHR Incentive Program with its laws around “meaningful use,” facilities will be able to both capture and share data (Center for Medicare and Medicaid Services [CMS], 2012). This should increase the ability to obtain patient outcome data by hospitals and clinics with a reduced amount of required abstraction. It should also reduce human error in abstraction. With the sophistication of EMRs, the data should be more readily available. The next hurdle is that not all EMRs are the same so the exchange of data may not be complete. As EMR interoperability increases, this challenge should be reduced. It is the intention, at GPRMC, to have the proper personnel in place when that time comes.

### **Maintaining an Edge**

Establishing a quality training system for new personnel is not necessarily enough to guarantee continuous results. There is on-going work required of everyone in the department to ensure optimal results. In order to keep what has been accomplished so far optimized, GPRMC management will review and improve processes and procedures on a regular basis through the written goals evaluation process. Productivity will be monitored to continuously streamline the process for effectiveness and efficiency. And finally, should vendors make any upgrades or changes; there will be an adaptable system in place to notify the department’s employees and to implement the handling of any EMR required adaptations, in a competent manner.

### Chapter Three: Project Description

This project will result in current tools for training GPRMC HIM staff in proper procedure for imaging and processing documentation to meet the 24 hour turnaround requirement. This will not only assist a HIM professional in dealing with the change agents that EMR implementation requires, but will also support the staff beyond on-the-job training. This will enable the staff members' acceptance and establish their confidence when addressing the challenges that are expected with new policies and procedures.

The ultimate goal of this project is to provide technicians with the tools needed to enable them to be the most productive that they can be. The following tools will be developed:

- An overview Power Point Presentation for the overall understanding of the HIM operation
- An employee performance review form
- A printed/electronic training manual for HIM technicians in scanning, analysis, and release of information

The technician's productivity expectations will be clear, and performance will be optimized. Current available industry resources will be reviewed and evaluated, and the strengths will be implemented into the organization's HIM training program. The training manual will serve as a reflective checklist in the proper processing of patient charts.

The PowerPoint presentation will include an organizational chart of the GPRMC hierarchy; an explanation of her mission, vision, and value statements; and a historical review of the health information management (HIM) field with final emphasis of the job description and skill sets required of a HIM technician.

The electronic training manual will be available to all staff members on the departmental server. There will be a printed hard copy available. The training manual will cover all four technical positions consisting of the scan technician, outpatient deficiency analyst technician, release of information technician, and inpatient deficiency analyst technician. This product will allow new and non-credentialed staff members to develop a new skill set, refine existing capabilities, and enhance the current skill set of established departmental staff members.

With each of the four technical positions, an EMR chart order will serve as an appropriate foundation for proper application. Through this training plan, the employees will be encouraged to draw upon any previous HIM experience and to learn at a pace which allows him/her to fully develop their own uniquely personal understanding of the processes and concepts which are presented.

The training program will be initiated with two new staff members. They will each independently view the orientation PowerPoint presentation for a general foundation of understanding. They will each work through a section for three to four weeks. Some of this will be independent and some will be as a team approach. The training program is written in a style requiring much interaction with current staff. The new staff members will be required to provide feedback. Since there are various learning styles, the training program will be individually adapted, as necessary, by the clinical data repository supervisor.

There are three opportunities for reinforcement of the desired outcomes. The initial overview presentation encompasses all three sections of skill sets required to fulfill the job requirements, the hands-on learning will provide a breakdown of the specific application, and a final competency evaluation will be completed at the end of each section. The feedback from the new staff members being trained will provide ample opportunity for revision of the program.

Ultimately, the goal is to provide the most efficient utilization of the EMR, that the HIM department can provide, for top-quality patient care at GPRMC.

### **Chapter Four: Methodology**

This training plan focuses on the orientation, training, and career development of the HIM technical employee. The end result of this project is derived from researching AHIMA Body of Knowledge, various professional websites, and many research books. An extensive literature review focused on general principles involved in the development of a training program. An examination comprising the importance of standards and teaching styles, change management, and learning styles was completed. The literature review resulted in documentation and training of the proper and productive compilation of a patient's EMR by qualified HIM technicians. The correct analysis process will be given as an overview and then repeatedly applied through chart completion in an informal setting of mentor and preceptor. The rules of HIPAA will be applied for proper release of patients' medical information.

Of foremost concern was the selection of the most effective approach for instructing staff members. The design of the orientation, overview PowerPoint program (PPT,) and blueprint for the training manual resulted in a simplified, yet applicable approach. Skill sets, job requirements, evaluation of performance is paramount. After careful consideration, the emphasize will be for staff members to recognize that our organization's mission, vision, and value statements are of key importance for proper patient care at every level.

### **Chapter Five: Project Product**

The following items were developed as a part of this applied project.

- HIM Technical Employee Training Manual
- Performance Review Form
- Power Point Presentation Overview of the HIM Department

## **HIM Employee Training Manual**

Scan Technician

Outpatient Deficiency Analyst

Inpatient Deficiency Analyst

Release of Information Technician

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**DEPARTMENT SPECIFIC ORIENTATION CHECKLIST**

Department: \_\_\_\_\_

Employee Name: \_\_\_\_\_

**Must be completed within 90 days of start date**

<b>Safety</b>	<b>Completed</b>
Online safety requirements & timeline for completion	
Online HazMat information and location of MSDS sheets, Dolphin	
Evacuation routes, gathering point, safe areas	
Patient safety issues specific to this department including SBAR	
Role in emergency preparedness and the disaster call list for department	
Fire extinguishers, fire exits, alarm pull location, and Safety Flipchart	
Acronyms P.A.S.S. and R.A.C.E.	
Personal protective equipment	
Eyewash station	
Variance reporting process (online DOERS or other)	
Department specific infection control polices	
Department specific safety procedures	
Medication Use Variance Report Form (if applicable)	
<b>Computers</b>	
Kronos edits and expectations	
E-mail as used in department communication; appropriate use	
Department specific software	
Education specific software	
Downtime Procedures	
<b>Department Specific Policies &amp; Procedures</b>	
Department meetings and communications	
Department specific mandatory documentation	
Department tour, bathrooms, lockers	
Introduction to co-workers and key resource people	
Phone, FAX skills	
Phone etiquette	
Paging and pagers	
Dress code	
Name badges	
<b>Education</b>	
Education documentation	
Tuition reimbursement	
Mandatory training requirements	
Education/travel request and reimbursement from finance	
<b>Department Processes</b>	
Department mission	
Teams and performance improvement process	
Department plan of care/services	
Job expectations	
EMTALA regulations (if applicable)	
Job description review/requirements (certification/licensure)	
Equipment review	
Work order processing, help desk/online	
Location and ordering of supplies	
Opportunity to serve on committees	



Compliance	
Department specific quality initiatives	
Online employee suggestions	
Online administration policies	
Reporting medical errors/non-punitive	
Performance Improvement Action Plans	
Customer service expectations	
Competency assessment process	
Feedback	
<b>HR Policies</b>	<b>Completed</b>
Online HR policies and procedures	
Processes and policies specific to department	
Absenteeism policy, who to call if absent/sick	
Rest Periods/Breaks	
Schedule, holidays, time off requests	
Paycheck/advice of deposit distribution	
Parking guidelines policy	
<b>Confidentiality</b>	
Security responsibilities (employee, patients, charts)	
HIPAA regulations	
Code of Conduct	
<b>Other Department Specific</b>	
<b>Job Specific</b>	

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Director/Supervisor/Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Permitted authorized reuse of document developed by GPRMC Human Resource Department



## SCAN TECHNICIAN

### 1. HIM – Scan Tech Training Progression

---

SDS (Same Day Services) – this forces the new trainee to look at the document

EDS (Emergency Department Services)

OPS (Outpatients) (w/bar code only)

OPS (Outpatients) (odds & ends without barcoding)

---

OBV/OB (Observation-Obstetrics)

OBV (Observation)

---

IP (Inpatient)

BHS, BHSP, IOP (Behavioral Health Services) (Partial) (Intensive Outpatient)

---

Lab (Laboratory)

MADM (Medical ADMINistration)

PT (Physical Therapy)

---

HS (Healthy Start)

CVS (CardioVascular Service)

Rescan THINNED Charts

Clean Scan Machine

## 2. Scan Tech - AFFinity Charges (How to Find)

---

MRA>Account Mgmt >ACA

Type in **QUICK CHARGE VIEW**

## 3. Scan Tech - Behavioral Health Services (BHS) Back Scanning

---

BHS Back Scanning needs to be done on the new M15 Kodak scanner. (K01 grabs too many sheets through at a time).

- Prep by removing staples, paperclips, etc.
- Sequentially put into a neat pile, the most recent visit information first.
- Prep with a batch header sheet, document header sheet, and I've Been Scanned sheet.
- Scan with the new scanner in small groups of < 100 sheets per individual patient batch. (We don't want it skipping pages. We will append these partial batches later.)
- On scanner M15, in ChartMaxx (CHMX) Scan Operator (SO) (face up, feet first), click the scan icon.
- In CHMX, Quality Review (QR), append to previous (by right clicking on document), if necessary.
- Delete any blank pages and rotate to read vertically.
- Append partial batches to the original batch in QR click on the page number.
- Click on the shift key and hold with left hand.
- With your right hand scroll down with the mouse.
- Click on page number 25 then click and hold to drag up to the correct batch number.
- Click **green** check to complete.
- Click **blue** swoosh to import.

- CLOSE.

Notice that in CHMX Chart Editor (CE) importing the patient's account should show up under the 'patient information' tab.

#### 4. Scan Tech – Cardio Vascular Center Scanning Instructions

---

If the service label is CVS      use CV Outside Facility Documentation label

    “ OFC                      use for example: CV Imperial OFC Clinic Note

    “ OPS                      it is OPS

CVS Administrative Secretary has received instructions and one full label sheet on:

CV Outreach Lab, CV Pacemaker/ICD Monitoring, CV Outreach PROGRESS Note and CV Outreach PROCEDURE Note. The NPNPG Office Manager is also on board.

#### 5. Scan Tech – Chart Run at START of DAY

---

- Pick up the IP charts from OBV, ICU, 2E (infectious disease, pediatrics), 3E (OB), & 3W (medical surgery) on the chart run.

#### 6. Scan Tech - ChartMaxx Document Movement

---

To re-version a document from **obsolete** to **active** or visa versa.

- In CE, be in an obsolete version of the document that you want to make active.
- Modify.
- Make this document version current.

- Then a new line will appear.
- Do not copy signature (leave this alone).
- OK.

To move a document from under one tab location to fall under another tab location

For example, **Unknown HN Transcription** should be moved to **EDEL...**

- Modify.
- In the 'Document Type' line select EDEL-Emergency Dept Event Log.
- OK.

## 7. Scan Tech – Creating a Batch Header Sheet

---

To create a batch header sheet (CHMX)

- Select the **Scan Operator Icon**.
- From the tool bar select **Tools**.
- Select **Print Header Sheet**.
- Enter. (This will automatically go to the **Batch Header** tab.)
- Be certain that Batch Type reads **HIM**.
- Click on the **Search** button.
- Enter the PT's account number.
- Highlight the PT's name. (If entering more than one PT account number, click on the **Clear** button.)
- Repeat the previous two steps until the pile of charts is completed.
- Click on the **Retrieve** button.



- **Double Check** the **Destination** box. Be certain that the sheets will print to the “himpc” (big, black, copier) for printer destination.
- Click **Print**.

## 8. Scan Tech – Creating a Document Header Sheet

---

To create a document header sheet. (CHMX)

- Select the **Scan Operator Icon**.
- From the tool bar select **Tools**.
- Select **Print Header Sheet**.
- Enter. (This will automatically go to the **Batch Header** tab.)
- *Instead select the **Document Header** tab.*
- Be certain the Batch Type reads **HIM**.
- Click on the **Search** button.
- Scroll down to alphabetically select the document type desired.
- Select and if necessary, enter more than one document type.
- Print.
- Click on the **Retrieve** button.
- **Double Check** the **Destination** box. Be certain that the sheets will print to the “himpc” (big, black, copier) for printer destination.
- Click **Print**.

## 9. Scan Tech – Creating a Face Sheet

---

To create a face sheet (AFFinity)

- **MRC.**
- **REG-Registration.**
- Enter.
- Select **PRT-Print Forms.**
- Enter.
- Select **Reprint Face Sheet Only.**
- Enter.
- Enter the PT's account number.
- Hit F7.
- Select the proper printer device by typing "hi" (HIM department printer will populate in a drop down area).
- Select HIMML (ML indicates the Mail room location).

This is to be used for forms without Bar Coding. (e.g. Birth Certificates, Physician Orders, Diagnostic Imaging, Other Facilities, Other Medications, Trends, and Telemetry).

## 10. Scan Tech – Doctor/Clinic (DRCL) Scanning Instructions

---

These are not actually complete charts. They are Outpatient (OPS Loose Stuff), however, we can treat them like mini-charts.

- Keep the ‘**Consent to Treatment**’ document however, **do NOT SCAN**, retain for 90 days in the retention boxes

### OPTION 1

Scan Operator (SO module) – **HIM** Batch type

**REMEMBER: A signed referral form is a physician order**

Work through the pile, one chart at a time (there is no need to presort ☺ )

When the Batch **header missing**, **append to previous** pops up

- Type N for no.
- Click Enter.

### OPTION 2

Scan Operator (SO module) – **OPS** Batch type **REMEMBER: You will need to use a document header sheet**

- Sort out physician orders and black out the right half of the bar code.
- Use a Physician Order header sheet.
- When the Batch Header missing pops up, click OK.

**If EKG (pink scripts) are not signed – Toss them out**

**If EKG (pink script) is signed, use S.O. – EKG Batch type**

**If EKG(pink scripts (approx 15 pgs) is signed, use S.O. – Test EKG Batch type**

- Keep the Fax Cover sheets , they are bar coded
-

## 11. Scan Tech – Emergency Department (EDS) Scanning Instructions

---

**Initial preparation involves removing paperclips, staples and applying the correct patient label, if necessary.**

\*\*\* You may scan can under **OPS Loose** batch type, **if you do not have diagnostic imaging (DI) paperwork** to interlayer the EDS charts.

\*\*\* If you **do have DI paperwork**, scan in under **EDS** batch type.

- Keep the General Instruction sheet as the patient’s signature serves as acknowledgement of the discharge instructions.
- Keep any BHS or **signed** EKG sheets.
- Do NOT ‘Perm’ these charts.
- Remove the Face Sheet (FS) and use this to...
- **Log charts into AFFINITY.**
- Place the chart sheets in the following sequential order:
  - “Dis-Charge”, Transfer, or Refusal Form.
  - Trend Printout (includes Full Disclosure Printout, All Strips Report and/or Ambulance sheet).
  - EKGs (pink) if **no signature or writing – discard Do NOT Scan.**
  - “Other Facilities’ Documentation’ This may include a “Medical Diagnostic Imaging” exam sheet or a “Medication Reconciliation” (Admission) sheet.

**EXCEPTION for ED only: even if the “Medication Reconciliation” sheet is blank, it must be included in the scanning process.**

**EXCEPTION – if only FS and radiology report (no D/C forms are present,**

**Still scan in – no signature required.**

- RAYS ‘Radiology Report/Out Source’
- Call No. ‘Ambulance Run Report’

## 12. Scan Tech – FIND a Chart in AFFinity

MRC>CHA>FIN Enter Account #, F7.

The screen that pops up will tell you the patient’s discharge date, their account number, the type of service, and the status of the chart.

Perm (as in permanently filed)

Incomplete outpatient processing area

Incomplete inpatient processing area

Discharged

Equal Access (EA)

If chart is in PERM – find which day it was moved to perm so you know, approximately, in which 90-day retention box you need physically to search for the chart. You can do this by highlighting the account, F6 and click on the LOCATION HISTORY (bottom left).

If the chart is in Inpatient Analysis, look at the discharge date and locate that pile on the shelf.

If the chart is in EA go into AFF MRC>DEF>DEF>put in account #. This will tell you if the chart has any deficiencies and which physician is deficient on the chart. If any physician’s name is shown, highlight his/her name ENTER and if there is a sign or dictate deficiency this means it

is still in EA. This will possibly also tell you which pile on the counter to look in. Or it may also be on the EA desk or cart.

### 13. Scan Tech – Home Health Scanning Instructions

---

- Scan under **HIM** batch type.
- Use the document header Sheet ‘Home Health Documentation’ between each set of patient’s charts.
- End each patient’s chart with an ‘I’ve Been Scanned’ sheet. It goes in as a single document.
- There is **NO NEED to log in accounts**. The Home Health department is to have identified by name and account no., each sheet correctly.
- Remove any patient labels from the outside of the colored folders.
- Return the color folders to Home Health department through interoffice mail.
- EXCEPTION – **Yellow folders** are returned to the HOSPICE department.

### 14. Scan Tech – In Patient Chart Order

---

- Sort into piles ED, IP, OPS, SDS.
- InPatient (IP) – sort alphabetically.
- Log in all alphabetized IP charts.
- Make batch header sheets for all the IP charts.

## 15. Scan Tech – Inpatient History & Physical (H&P) STAMP Procedure

---

If a History and Physical (H & P) is done on a patient and they are kept a few days before the surgical procedure is performed, the H & P by the hospitalist will suffice. **No new H & P required. Does NOT need to be completed.** I.E. the patient comes in on Saturday, stays, and the surgical procedure is completed the following Monday. **No new H & P required.** This is valid whether or not we are talking the same or different physicians, because of the continuous monitoring.

If an H & P is done on a patient and they return home, come back a couple of days later, then the physician **must RED STAMP** that they have reviewed and that nothing has changed prior to the surgical procedure being performed.

**\*\*\* The STAMP validates that NOTHING on the patient's status HAS CHANGED.** The stamp is **MANDATORY** for anything older than >24 hours and <30 days.

**OTHER FACILITY DOCUMENTATION is commonly used for the Short H & P form, if it has the red H & P stamp within 48 hours of surgery!**

## 16. Scan Tech – Medication Administration (MADM) Scanning Instructions

---

- Remove paperclips and staples.
- Log in as HIM batch type.
- Discard/shred wristbands.

- Scan Physician Orders (black out right-most side of the barcode and use a document header sheet).
- Sort out consent forms and retain for 90-days. DO NOT SCAN.

If there are duplicated physician orders from any other service type, use the attached MADM patient labels and overlay

### 17. Scan Tech - Ordering Supplies On-line

- Contact Sharon Sewald in Materials Management to be set up. There is only one person authorized from within each department for this responsibility.
- Internet Explorer>Lawson Self –Service (portal) User Name> Password.
- Click Shipping.
- Find/shop (top blue). This is the template for items on list (done on Monday mornings).
- Click Location Templates.
- Complete the quantity by putting in the number desired.
- Write # of items> cost> date>release # on back page of order.

For SPECIAL ORDERS click on find/shop> click on special/service>Type item #, tab, brief description, quantity. UOM (unit of measure) ea, bx, cs click on the down arrow and the catalog will identify which to use. **COST = \$1.00 ALWAYS.** Account – 6400 – add-release.

- Write requisition # down and date of order for future reference.
- Click OK.



## 18. Scan Tech – Pulmonary Function Test (PFT)

---

These are Color inked reports with a Spirometry table.

Scan in as Pulmonary Function Test (**PFT**) batch type, not as OPS Loose or HIM

## 19. Scan Tech – Physical Therapy Scanning Instructions

---

**Scan tech serves as the QR tech for all PT. Not the D.A. or E.A.**

### A. Initial Phase – Patient begins therapy

- Enter **REHAB Initial Evaluations** (3-page set without signatures).
- Remove staples.
- Alternate each chart with its own document header “REHAB Initial Evaluation.”
- Scan under **OPS Loose** batch type.
- QR.
- Upload.
- DONE.

### B. Patient is discharged – complete chart is brought to HIM for processing

- Scan **HIM** batch type.
- Print batch header sheets.
- Complete charts with “I’ve Been Scanned” Sheets.

**CHART ORDER:** Physical Therapy **PT**,  
Occupational Therapy **OT**  
Speech, Language Pathology **SLP**

1. Physician Orders. **Requires Physician’s Signature, date/time**

## 2. Alphabetize. OPTIONAL

- a. Attendance Form.
- b. **REHAB Initial Evaluation.**
- c. Physical Therapy documentation.
- d. REHAB FCE (Joule Functional Cap. Evaluation).
- e. REHAB General Exercise Flow sheet (could be more than one). Sports Therapy Doc is also included here.
- f. REHAB Patient Subjective Information.
- g. REHAB Plan of Care.
- h. REHAB PTEX – exercise pictures.
- i. **REHAB Recertification/ Dismissal** (go by dates).
- j. REHAB Referral for Therapy.
- k. SLP Comprehensive Evaluation ‘Document Review Report’.
- l. SLP Documentation.
- m. SLP charts **DO NOT include Initial Evaluations**

## 3. Back end stuff without bar codes

- a. Progress Notes –General Admission orders – Referral all are to be (Chronological order, i.e. Jan 1<sup>st</sup>, 2<sup>nd</sup>, etc).
- b. Insurance Verification.
- c. Other Facility Correspondence also includes the MEDICATION LIST.
- d. Release of Information.
- e. Privacy Authorization Form (HIPAA / HITECH).

- Keep the FS for rescanning the signed “Initial Evaluation” after removing the original, unsigned version.
- Keep the “Consent for Treatment” in the 90-day retention boxes. DO NOT SCAN either the FS or Consent for Treatment.

• **DO NOT scan Insurance cards! DISCARD.**

### **In (ChartMaxx) QR**

Use the correct code of **HIM** for the scanner>apply>close. Double click on the top blue batch bar. Apply if correct, delete blank pages, split to start a new type of document, when necessary.

### **C. Delete the Initial Evaluation without the physician’s signature**

**Obsolete scanned in, unsigned REHAB Initial Evaluations and replace with signed REHAB Initial Evaluations.**

- **In (ChartMaxx) CE**
  - Look for the REHAB Initial Evaluation. The lowest one in the grouping is the first one scanned in WITHOUT the physician’s signature.

• **Delete the Initial Evaluation without the physician’s signature**

## 20. Scan Tech – Physician Census Mail to Mailboxes

---

- **DISTRIBUTE** by physician’s last name except for the following:

Physician Census that kicks out from fax machine

**DISCARD**

ER physicians’

Dolbey dictation print outs during the day

Hospitalists'

Locums'

**DISCARD**

Locums

Cardiologists

## 21. Scan Tech – Prep, Quality Review, and Analyze

### Prepping

- Log in charts into AFF.
- Print batch headers.
- Remove staples, yellow sticky notes, and paperclips.
- If necessary, apply patient labels to documents.
- Place in proper chart order.
- QR Quality Review.
- Check each label to review for proper patient account.
- Append where necessary.
- Correct Document name, if necessary.
- Square up paper so it is neatly readable.
- Double check for proper chart order.

### Analyze

- For physician signatures, date and time ONLY on:
  - Physical Therapy (PT).

- Cardiac Rehab.
- Pulmonary Rehab.

All other charts will go to Inpatient or Outpatient shelves after they are scanned.

## 22. Scan Tech – Printing ‘I’ve Been Scanned’ Sheets

Go into Intranet > GPRMC Information > Hospital Forms > General Forms> HIM Forms > I’ve Been Scanned. Print off 200 copies at a time.

## 23. Scan Tech – Priority List for Scanning in Charts

First thing every day, begin with EDS and follow chronologically finishing with the Fetal Monitors, which will be the last concern.

- EDS (Emergency Department) and together do the radiology outsource, AKA Diagnostic Imaging (DI).
- SDS.
- IP (MED, SURG).
- Advanced Directives.
- Lab, OPS, PFT, Sleep Studies (Should be done together because most of these documents go to the same patient after they have been scanned in. It just makes it easier to track.)
- MADM.
- ROI.
- Rescanning completed, THINNED, Inpatient charts.
- PT.

- Home Health.
- Fetal Monitors (last).

#### 24. Scan Tech – Radiology AKA Diagnostic Imaging Instructions

---

- Add Document header, “Radiology Report/out source”, to the pile to be scanned.
- Scan in **OPS Loose** batch type.
- Enter the patient’s MRUN from the report.
- Look for correct “study date.”
- Click RETRIEVE button. (If the account does NOT appear, use (*Affinity*) charges to validate procedural date.) (This will identify the correct department of the procedure. Most common are ED, MED and occasionally BHS or OBV.)
- Click the arrow to the right of APPLY >.
- Repeat the process for each patient.

#### 25. Scan Tech – ROI Scanning Instructions

---

For ROI

**REMEMBER: event date when QR**

- Search for the account # by using Patient’s Date of Birth (DOB).
- Retrieve button.
- OK.
- Match the patient account visit to the respective Date of Service (DOS).

26. Scan Tech – SANE/SART Restricted Confidential Charts – group listing

The screenshot shows a software window titled "Chart-Specific Security for Acct# 010936721". On the left, there are checkboxes for "Restricted" and "Confidential", both of which are checked. Below these is a "Last Name" search field and radio buttons for "Find Users" and "Find Groups". A "Search" button is present. At the bottom left, there is an "Expiration Date" dropdown menu set to "02/16/2012" and an "Add >>" button. The main area is titled "Current Chart Permissions (Includes groups with general permission)" and contains a table with the following data:

User/Group Name	Chart-Specific Override	Assignment Date	Expiration Date
Case Management (Group)	Granted	2/15/2012	
Clinical Registration (Group)	Granted	2/16/2012	
ER Medical Staff (Group)	Granted	2/15/2012	
ER Sane/Sart (Group)	Granted	2/15/2012	
ER Staff (Group)	Granted	2/15/2012	
HIM Admin (Group)	Granted	2/15/2012	
HIM Coding Staff (Group)	Granted	2/15/2012	
HIM ROI (Group)	Granted	2/15/2012	
HIM Staff (Group)	Granted	2/15/2012	
HIM Transcription (Group)	Granted	2/15/2012	
Nursing BHS (Group)	Granted	2/15/2012	
Nursing Supervisors View Only (Group)	Granted	2/15/2012	
PFS Administrator (Group)	Granted	2/16/2012	
PFS Billers (Group)	Granted	2/15/2012	
PFS Clerks (Group)	Granted	2/15/2012	
PFS Patient Account Coordinator (Group)	Granted	2/15/2012	
PFS Registration Coordinator (Group)	Granted	2/15/2012	
Psych Staff (Group)	Granted	2/15/2012	
REG Auditor (Group)	Granted	2/15/2012	
REG Clerks (Group)	Granted	2/15/2012	

At the bottom of the window, there is a note: "Note: General Permission indicates user/group, by default, can view this chart." and "OK" and "Cancel" buttons.

27. Scan Tech – Scanner Cleaning Instructions

KO1 Scan Machine

Light Bar

- Replace the glass bar by placing the notched out chip in the top right-hand corner, slide the glass bar between the metal bar and two metal clips.

- Push the left side of the light's glass bar down and then slide to the right. Pull the glass bar out.
- Wipe the glass bar with an alcohol wipe, use Kleenex tissue to dry and avoid leaving finger prints.

#### Black rollers

- There are 7 rows beneath the glass bar and 6 rows of black rollers on the raised lid. Use an Optic Cleaner Pad to wipe off the rollers. Spin to clean as many rollers as possible, not all will spin.
- Using the CONTROL button on face of the scan machine,
- Press Full Clean to System
- Insert sideways (wide side to hit all roller, etc) a Bell & Howell cleaning sheet (8 ½ x 11) and run two of them through multiple times.
- Click the CLEAN MENU button

#### START Camera Calibration

- **ALWAYS START** with the back scanner first.
- Click the button to start. The process will take awhile, (about 2 minutes) so be patient.
- Clean the front scanner by selecting the appropriate button.
- Exit.



## 28. Scan Tech – Same Day Services (SDS) Chart Order

---

1<sup>st</sup> PORTION (anything with Dr's signature)

- Face Sheet (FS): demographics KEEP but do not SCAN.
- H&P's: (Short Form H & P's are GPRMC's H & P's) Keep all, including those H & Ps from Internal Medicine or other facilities that are within the 30-day window of the Date of Service. Must be signed, dated and timed! May include a telephone order (TO) or verbal order (VO). REMEMBER: 'Document Review Report' with the red stamp is an H & P. 'Consultation' with the red stamp is also an H & P.
- Discharge Medications:
  - Keep ALL pages if there is any writing on any of the pages.
  - Check for the physician's signature, date and time.
  - Set aside for **SCRIPT** batch type, if a prescription is included.
  - Add an attached patient label, if available, over scanned copy label.
- Physician Orders: (anything with the Dr's signature. Must also include date and time)
  - Admission Orders (General Admission Orders/Invasive PAT/SUR)  
Chronologically include the full document set.
  - Warfarin (Coumadin) Orders.
  - Adult Anesthesia **Pre** Procedural/Operative Orders.
  - Intra – Operative Orders.
  - Post-Operative Orders.
  - Post anesthesia Orders (All physician orders go in chronological order by date & time).

- Admit/Transfer Medication.
- Progress Notes.

2<sup>ND</sup> PORTION (anything without the Dr's signature)

- Consents:
  - Consent for Treatment (to 90-day retention box. REG already scanned in).
  - Consent for Anesthesia.
  - Consent to Operate.
  - Informed Consent.
  - Consent for Transfusion.
  - Authorization & Consent for Special Diagnostic or Therapeutic Procedure.
  - Short Form Operative Notes or Post Procedure Notes.
  - Anesthesia Follow Up.
  - Implant Tracking Record, human tissue.
- Medicare forms.
- Telemetry strips (grey on white).
- Anesthesia Documentation **green**.
- Post-Anesthesia Care Unit (PACU) **blue**. \*\*\* Double check on the back side, there may be taped and folded EKG strips. Be certain all information is visible for scanning.
- Central Sterile Tracking documentation.
- Stress Test.
- Trends.
- Telemetry Strips.

- Heart & Vascular Hemodynamic Procedure Report.
- Down time forms.

3<sup>rd</sup> PORTION (anything not from our facility) but still a part of our EMR. No sequential order.

- Pre Operative Check List.
- Patient Item Clothing List.
- Bi-pap Instructions (or anything other instruction for specific things).
- Dismissal Instructions.
- Other Facility Correspondence.
- Other Facility's Medication List.
- Ambulance run sheet.
- EKG report (only if initialed- means it was referred to for patient assessment).
- Photo- scan separately in numerical order under scan batch type PHOTO.
- Prescription- scan separately under scan batch type SCRIPT.
- I've Been Scanned.
- Attach to chart, but **DO NOT scan** in the FS.

## 29. Scan Tech – Sleep Center (SC) Scanning Instructions

---

- Scan in **HIM** Batch type.
- Select document name 'SC Clinic H & P Notes' for non-bar coded documentation.

Be forewarned the scanning machine will stop scanning, and pop up the message

Batch header missing,  
Append to previous?

However, override this safety feature by clicking N for NO and Enter

- All other documents have the correct bar code so order is irrelevant.

### 30. Scan Tech – Start of Day Itinerary

#### CHART RUN IN THE MORNING

- Need rubber bands.
- Grab mail and inter-office envelopes from basket behind D.A.
- OUTPATIENT  
Code 531, turn lock.  
Bin in corner.
- FINANCIAL SVCS  
Drop off mail and pick up mail.
- ER  
In black bin behind the check-in at desk, or ask the guard. If here is a red envelope, give to Clinical Data Repository Manager.
- SAME DAY  
Behind desk (may have to ask).
- RADIOLOGY  
Last bin.
- OBS  
Corner of the counter.

#### 2<sup>nd</sup> Floor

- ICU

Bin on top of gray shred box.

- East

Bin on floor.

3<sup>rd</sup> Floor

- 3W

Bin on shelf.

- OB

Bin in cabinet.

**@ 6:40 a.m.**

- ✓ Take paper and fill copier.
- ✓ Grab Physician Census list and distribute in the Doctors' respective mailboxes.
- ✓ Dr. Freitas' get faxed to his office first, then secondly, put into his mailbox.
- ✓ Anesthesia goes to Donetta in an inter-office envelope to NPNG.
- SORT CHARTS.
- LOG IN.
- MAKE HEADER SHEETS.

---

**AT DAY'S END,** check the Lost & Found Tab in CHMX and also 'unknown documentation'.

### 31. Scan Tech – Developing a Tool for Document Identification

To help with identifying information, here's a learning tool that has worked in the past:

- Photocopy the form and keep it in a three-ring binder.

- Write notes on the top of each **de-identified sheet**.
- **Keep in a three ring binder.** For example: PFT-Scan as PFT. Name as PFT Pulmonary Function Test-Scanned. This should help when QRing things and trying to remember what they are. Find the forms on your own... more sticking power in recognition.

**And STRESS- the tech needs to de-identify and patient information with a permanent black marker. The notebook should NEVER leave the department.**

## INPATIENT/EQUAL ACCESS DEFICIENCY ANALYST

### 1. IP Assigning a Deficiency

---

In AFF.

WF Operator>Deficiency Analysis>Ok, highlight a service such as (SDS/OBV/PCOU).

Enter the discharge date.

Short Form H & P needs to be within 30 days.

Short Form Operative note.

MRC>DEF>DEF enter patient's account number.

Deficient party: Enter physician's last name.

Click on or type in the corresponding number. (i.e. 20 Pending Operative Note).

Job number (enter the DVI job number).

Print Deficiency Analyst sheet?

Once printed, put in brown, accordion pleated folder labeled 'pending' on middle shelf EAST wall E.A. location.

In AFF, move the chart (C ) to E.A. [means it is waiting to be typed up]

Once completely done move to (PF) perm file.

FYI Dr. dictated, but report is not yet typed by transcription, 'Pending '

Dr. did not dictate, 'assign deficiency'.

## 2. IP Deficiency Dictation Removal

---

- These papers are located on the counter behind the desk in Equal Access. They are placed there in a burgundy colored basket. Transcription automatically generates these from dictated reports at the HIMPC printer.
- This should be done once a day.
- In the upper right hand corner of the paper the top line will have either a physicians name or say CHART COPY.
  - Chart Copy: check for deficiencies
  - Physician's name: Place in that physician's mailbox in EA. \*Never discard anything that has the physician's name on it, unless you know that this physician does not wish to have their own Chart Copies \* If it is not a physician with Great Plains Regional Medical Center, or if the physician is a local physician without a mailbox, place in the burgundy box on top of the Outpatient Analysis box; used specifically for sending out mail to local physicians.
  - **At this time 06/2012; Drs. Arteaga, Ali, Nelluri, and any hospitalist, or psychiatrists, do not wish to have chart copies for their office, DISCARD.**
  - If this dictation is a letter from MONC or RONC to a physician, there is often a list of physicians that are included in the care; this letter generally goes first to the surgeon, then to the primary care physician.
  - Sometimes that line states "Vicki's Copy", "Vali's Copy", "Stan's Copy", "Sheelagh's Copy". Place that on the corresponding person's desk.



- If there is not an account number on the sheet, it is most likely a “No Visit H&P”, place this on the Equal Access Desk.
- If there is anything unusual about the sheet, it may be something Transcription needs clarified with Equal Access; place this on the Equal Access Desk.
- Certain papers may be discarded without checking for a pending deficiency. Located in the upper left hand of the paper are the **Loc/Svc:** if these types of service are indicted, simply discard:
  - CV (Cardiovascular).
  - OFC (Office Visits).
  - DRCL (Doctor Clinic).
- Located in the upper left hand corner are report types. Certain report types do not need to be checked for deficiencies. They can be discarded.
  - Progress notes.
  - Inpatient Progress Notes.
  - Psychiatric Progress Notes.
  - MONC Notes.
  - Letters.
  - Assessment (these are for Behavioral Health Accounts).

## INSTRUCTIONS

1. Open Affinity.
2. Go to MRC-Medical Records Control, Enter.
3. Go to DEF-Deficiency Control, Enter.
4. Enter the patient account number from the upper right hand corner of the paper, Hit F7 on the top line of the keyboard.
5. If the screen does not change and the very bottom of the screen on the left side is a line stating, "Account # must first be logged in" nothing more can be done...discard.
6. If the information comes up without any deficiencies stating "NOT FOUND" close out and discard the paper, nothing more needs to be done; exit out and begin again.
7. If the deficiency list appears, find who did the dictation at the bottom of the paper chart copy; the words **Dictated By:** will indicate whom you should choose.
  - a. If there is nothing by that physician, discard, and close out the deficiency list.
  - b. If there are deficiencies assigned, select that physician; make sure the Report Type matches the deficiency being removed (i.e. only remove a pending operative note/dictate operative note, if the information on the chart copy is an operative/procedure note).
  - c. If it is a pending note, remove the deficiency, discard the sheet.
  - d. If it is a dictate note, remove the deficiency, locate that particular chart in Equal Access, make sure you do not leave the chart somewhere that a physician may accidentally dictate the report again. (in their pile on the counter, in their files, etc.)

\*This is very, very important to do, physicians hate to dictate twice, and transcription does not have the extra time to transcribe reports twice, then EA has

to take the time to discuss the situation with the physician and ask them which report they want.\*

8. To remove the deficiency, type in the corresponding assignment number (i.e. #20 for pending operative note, #12 for pending discharge summary, etc.).
9. Hit the F9 button on the top of the keyboard, Enter.
10. If this **does not** complete all deficiencies
  - a. Enter, you will be prompted to enter your password.
  - b. Type in your password, enter.
  - c. You will be prompted to print a new deficiency sheet: **select NO**.
  - d. Enter, Begin process again.
11. If this **completes** all deficiencies:
  - a. The “Deficient Parties on File” screen will appear, under the 3<sup>rd</sup> column for CMP date (Complete deficiencies date) the current date will appear, Enter.
  - b. You will be prompted to Enter your password.
  - c. Type in your password, enter.
  - d. You will be on the deficiency analysis screen, ready to type in another patient, **INSTEAD:**
  - e. Hit the PAGE UP button twice, until the top line of the screen says CHA-Chart Tracking.
  - f. Enter, select the top row ADD-Add Chart to Permanent File.
  - g. Enter, Move Chart or Batch, type in the letter “C” for Chart.
  - h. Enter, a list will appear of choices, select the PF-Permanent File line (you can do this by hitting the “P” button or by moving using the arrow buttons).

- i. Enter, type in the patient account number.
  - j. Hit F7 from the top row of the keyboard.
  - k. The account will appear.
  - l. Enter, “Okay to File” will appear, Yes is an automatic prompt.
  - m. Enter, Account Filed box will appear, Enter.
  - n. Discard the dictation.
  - o. You will be back at the screen from instruction “f”, hit the page up button twice.
  - p. You will be on the screen from instruction, “e”, arrow down one choice and select DEF-Deficiency Control, Enter.
  - q. Select DEF-Deficiency Analysis, Enter.
12. You will now be at Instruction #7. Begin the process again. Repeat until the entire pile of deficiencies is gone.

### 3. IP DVI Instruction

---

You may locate a physician’s report in question by looking up either dictation or if it’s done.

Open record filter.

Record job #.

Search – ALL Reports – **delete the work types.**

Listen from one day previous => all of them.

Look in CHMX, if it’s there – ignore. If it’s missing EA should inform Transcription Supervisor.

FILE F2 work type

F3 dictators

Sort by user, not user ID.

Author ID - enter the 3 or 4 digit # for the corresponding Dr.

**ALWAYS delete work type** and listen from one day prior.

#### 4. IP Electronic Signature Instruction

---

- This report needs to be looked at weekly.
- In EA, this report needs to be printed in its entirety, to ensure that all older signatures are caught.

Instructions:

1. Open Eclipsys/SCM/AllScripts.
2. On the top bar, go to the printer icon; while hovering over it, the words “Print Reports” should appear.
3. Open; on the center drop down menu labeled “Report Category” select “Administrator.”
4. Open; select “Signature Report by Provider.”
5. Print.
6. As the pages come off the printer begin sorting them into four sections.
  - GPRMC physicians/local physicians who need to sign.
  - Out of town that need to be followed up on.
  - Locum/other physicians that need to be followed up on.
  - Discard Pile.

7. For GPRMC physicians and local physicians with a mailbox:

- See how many pages the physician has in unsigned electronic signatures. If the number is larger than around ten pages; or the signatures seem to be older (More than a month old) Staple, Stamp with the “Reports Need Electronic Signature” Stamp, place in their box.
- Keep a list of these to follow up on in the next week. Make sure these signatures are completed. A physician can also be suspended for outstanding electronic signature, just like they can for other deficiencies.
- If there are not very many pages, or they are very recent, just discard.

8. For out of town physicians:

- If they are recent electronic signatures-discard, the outpatient analysis clerk completes these bi-weekly.
- If they are older (30 days or older) highlight the specific deficiencies, and give to the outpatient analysis clerk to follow up on.

9. For locums & those without electronic signature:

- Staple together.
- Set aside for signature checks.

5. IP No Account History & Physical Accounts

---

\*These accounts will be PreAdmit Testing (PAT) accounts; OBV; SDS.

\*Do NOT choose Surgical PreAdmit Testing (SPAT) accounts.

\*This report is done daily; every morning. The results are given to Transcription Supervisor.

\*These are sent to the HIMML or HIMPC printer and kept in a red folder on the left side of the EA desk.

1. Open Affinity.
2. Go to MRC-Medical Records Control.
3. Open CHA-Chart Tracking.
4. Open FIN-Find/Request Chart/Volume.
5. Check the date of dictation. Write that on the upper left hand part of the page for one month PAST that date. Example Dictated 05/12/2012; write 06/12/2012 this is the expiration date of the H&P for current use.
6. If the dictation is past 30 days old, write “TOO OLD” on the top of the paper; set aside
7. Using the Medical Record Number (MRUN) on the top right hand of the History and Physical search the patient.
  - a. If you do not have an MRUN search by the patients name.
  - b. Use the date of birth as additional information to help identify the patient.
  - c. Write the number you locate as the MRUN for that patient on the H&P.
  - d. If there is more than one name and no other identifying information; look in each of the patient’s accounts searching for a PAT number.
8. If there is NOT a PAT number set the H&P aside.
9. If there IS an account number, write the number at the top of the paper to give to Transcription.
10. If there is an OBV or SDS account number from the day before or currently open,
  - a. check in Chartmaxx to see if that account number is for the health situation on the H&P.

- b. if it matches, write that account number on the paper for Transcription.
  - c. if it does not match, set that H&P aside.
11. When all of the H&Ps are completed;
- a. The ones that did not have an account number need to be returned to the red folder.
  - b. The ones that did have an account number and those that are too old are taken to Transcription.
12. Transcription will move these to the correct account; and dispose of the ones that are too old.
13. When Transcription returns them to you; go into Chartmaxx to make sure the transition went correctly and the H&P is there.
14. If the H&P is not there; check in Eclipsys/AllScripts to see where the flow of information was halted.
- a. If it is in Eclipsys, but not in Chartmaxx, take to the Chartmaxx supervisor.
  - b. If it is not in Eclipsys, let Transcription know; and she will re-send it.
15. Repeat this process daily.

## 6. IP Obstetrics Instruction

---

### 1<sup>st</sup> Portion

Labor and Delivery Summary (white with mother's chart, and is scanned with the chart)

(Yellow to NB chart, shred once prepped)

Discharge Meds



H&P's (bar code named first, if there is one)

OB flow sheets (from other facilities or generally the H&P)

**Physician Orders** (anything with physician's signature and chronological order ALWAYS)

3 pgs Labor Induction/Augmentation Orders

1 pg Labor and Delivery Observation Admission Order

2 pgs Ante-Partum Orders

1 pg Epidural Order (written)

2 pgs Labor Epidural Orders

1 pg Pneumococcal/Influenza Immunization Protocol

Pre Op C-Section Orders

Post Op C-Section Orders

2 pgs Adult Venous Thrombolism Order

2 pgs Post Partum Orders

**\*\*\* Arrange in this order, not by dates**

Progress Notes

## **2<sup>nd</sup> Portion**

Consents

Authorizations (includes Request/Authorization for Sterilization)

Operative Notes

Anesthesia Post Op Follow-Up

Green

Blue

Pre Op Procedure (no signature)

Any other documents (mostly educational information forms)

### 3<sup>rd</sup> Portion

Clothing List

Discharge Orders

FS

Chart Notes

## 7. IP 14-Day Physician Deficiency Letter

---

1. Change date for the 14-999 day letter

MRC

AGI

Click on down arrow

Choose 14-999

Enter, enter, enter

F2 to edit

Place cursor down on date and change to this weeks Wednesday date in 2 places

(1<sup>st</sup> paragraph and 2<sup>nd</sup> paragraph)

F2 to exit edit & enter password

2. Run 14 day letters

MRC

DEF

RPT

LTR

Click down arrow

Choose 14-999 day,

click ok

F6

Choose printer

3. Check Health Notes for all dictates and pendings on 14 day letters.
4. Keep letters in alphabetical order as you work them.
5. Do not send letters to Locums.
6. Remove, in Affinity and on the chart, any deficiencies for dictates or pendings that you find in Health Notes. Then reprint the letter for that Doctor.
7. Do not send either 14 day letter if 5 or less signatures only. If any # of dictates, the letter must be sent. If over 5 signatures only, the letter must be sent.
8. If a 14 day letter has a dictate or physician query that is on the Medicare List (the Coding Supervisor will give you Monday morning) it will be sent certified. Also send certified letter if any charts to dictate or physician query are over 21 days old whether they are on Medicare list or not.

9. If certified because on Medicare list, highlight (on white original and green copy-pink shows up best on green) the 1<sup>st</sup> paragraph of the letter, Medicare Alert, and the entire line with patient name and account info, then write a **C** in the upper right hand corner on the 1<sup>st</sup> page of the letter.
10. If signatures only are on the 14 day letter, cross out the 1<sup>st</sup> paragraph, 2<sup>nd</sup> paragraph after “4:00pm” and 3<sup>rd</sup> paragraph. This is what the Doctor’s refer to as “the threatening part”. If dictates but none on the Medicare list, cross out 1<sup>st</sup> paragraph.
11. Copy 14 day letters to green paper. Staple pages together if more than 1 page for each Doctor.
12. Staple all white originals in 1 bundle, they will eventually go to the front in the hanging folder containing previous week’s originals. When Certified mail receipts come back, staple them to the bundle.
13. 14 day letters that are not certified get put in an Inter-department envelope To: Doctor name, From: Stan Johnston, HIM.
14. Get out a blank form “Physician Office Notification Log”. List all Doctors receiving a 14 day letter. In the column “Certified???” write a **C**. In the column “message # signs, dictates...” write # of dictates (#Medicare in parenthesis.), # of queries (#Medicare in parenthesis.). Call all of the Physician offices with a **C** to notify of 14 day letter certified letter.
15. A call should go like this, “Hi, this is (your name) in HIM at the hospital. I need to get a message to Dr. (name). The message is from the HIM Director. The message is, Dr. (name) is getting a certified 14 day letter. That means he has charts over 14 days old. He

has \_\_\_\_# of charts to dictate, \_\_\_\_# charts that have a coding query. These need to be done by this Thursday, (Month and day) at 4:00pm.”

16. Email Clinical Data Repository Mgr, Coding Supervisor and HIM Director with this format: Subject “day/month/year 14 day Certified Letters”, body: “Dr. (name), # dictates (#Medicare if any in parenthesis.), #query (#Medicare if any in parenthesis.)”
17. Enter the number of certified letters on the HIM Tech Stats Excel sheet on the Home drive.

## OUTPATIENT/EQUAL ACCESS ANALYST

### 1. D.A. Advanced Directives Instructions

---

CHMX> CE> enter MRUN> highlight all accounts that pop up.

View Universal. Look in the universal to find the date of **the current copy** of advanced directives.

**\*\*\* If the ADVANCED directive documents signature date is not the same** as what is showing use that date as a clue to look in visits to locate when it was last scanned in by REG.

Be certain the Advanced Directive is highlighted, Click  . Correctly **enter the signature date** of the official document, in the 'Document Event Date 'line. Click OK

Since the date cannot be modified in UNIVERSAL view, you must work up changing the advanced directive document to the properly correct signature date. Once completed, return all charts. Go back into the MRUN to be certain the Universal view is now pulling the correct signature date. Retain all advanced directive copies for 90 days.

Return to Mona for audit review. Not to be included in the chart going to the IP/E.A. tech.

### 2. D.A. Faxed Radiology Reports

---

The Preliminary "RAYS" Radiology Report/Outsourced arrives on our fax.

Use the MRUN on the preliminary report to look up the correct, corresponding account visit number in CE. Write this account number on the upper right-hand corner

Print off a Document Header Radiology Report/ Outsourced and scan in under OPS loose.

### 3. D.A. Assigning Deficiencies

---

In AFF

WFOperator>Deficiency Analysis>Ok, highlight a service such as (SDS or OBV).

Enter the discharge date

Short Form H & P needs to be within 30 days

Short Form Operative note

MRC>DEF>DEF enter patient's account number

To the left

Deficient party: Enter physician's last name

Click on or type in the corresponding number. (i.e. 20 Pending Operative Note)

Job number (enter the DVI job number)

Print Deficiency Analyst sheet?

Once printed, put in brown, accordion pleated folder labeled 'pending' on middle shelf EAST wall E.A. location.

In AFF, move the chart (C) to E.A. [means it is waiting to be typed up]

Once completely done move to (PF) perm file.

FYI Dr. dictated, but report is not yet typed by transcription, 'Pending'

Dr. did not dictate, 'Assign Deficiency'.

#### 4. D.A. Birth Certificates Instruction

---

Take the 2-page copy of the birth certificate, look at the MRUN, enter the MRUN into AFF. Correctly update the name in AFF (MRI>PAT>PAT). Record the account number in the upper, right-hand corner of the birth certificate. Confirm the Date of Birth, Sex, and race of both mother and baby. (use the LINK tab in CHMX) If something appears incorrect and you believe a correction change is required, contact the OB secretary (Kari Turner). Scan it in under OPS Loose.

Give to Mona when completed.

#### 5. D.A. Out-of-Town Physician Mailing

---

SORT THE DOCUMENTS FOUND IN THE BURGUNDY FILE BOX ABOVE D.A. WORKSTATION. SORT ALPHABETICALLY BY DR. LAST NAME MAKE SURE TO KEEP EACH DOCTOR TOGETHER

LOCATE ADDRESS FOR DOCTOR

ADDRESS LOCATIONS:

- ✓ MEDICAL STAFF ROSTER: LOOK HERE FIRST

ACCESS THROUGH **OUTLOOK EMAIL**. CLICK ON PUBLIC FOLDERS- ALL PUBLIC FOLDERS-MEDICAL STAFF-ROSTER – DOUBLE CLICK TO OPEN THE ROSTER (THIS WILL HAVE LYNDA WILKINSON’S NAME. CONTROL-F TYPE IN FIRST FEW LETTERS OF PHYSICIAN’S LAST NAME. YOU MAY FIND



THE NAME ON THE FIRST CLICK. I HAVE FOUND SOMETIMES IF IT DOESN'T COME UP ON THE FIRST CLICK , CLICK AGAIN MAYBE EVEN A COUPLE OF TIMES

✓ HIM DEPARTMENT ROSTER

HIM HOME DRIVE d718\_home on mdsvr 017(H:)

HIM TECH>OTD>Double click on out of town addresses

The addresses will pop up. You can use the control F feature on this roster as well.

- ✓ Oncology reports-send an email to Pam Short and Ann Johnson (IN ONCOLOGY) asking for their assistance in obtaining an address. I give them the physician's name and reference the patient and MRUN #
- ✓ There is also a big thick address book with NE and Western NE healthcare facilities, physicians, APRNs, PA's etc. However you must call and verify these addresses as they are not always correct. It's amazing how fast some of these doctors move around.
- ✓ Google is another resource. Again call and verify the address when you have gotten from Google.
- ✓ There is also a running list in the blue notebook that is in the file box with the documents that need to be mailed. Input these into the department register.

After obtaining the address, address the envelopes, (make sure the envelope has been stamped HIM in the left address corner.) Insert the document and put in the outgoing mail. Count the envelopes that are being sent out and enter into the stats for that day.

## RELEASE OF INFORMATION TECHNICIAN

### 1. ROI The Most Common PHI Requests

---

Since we use the RIMAGE system, most of our ROI documentation is automated.

The AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION form requires a requestor's signature after they have thoroughly completed the form. All patient records are required to be placed in an envelope prior to leaving the HIM department.

Check the requestor's government issued, photo ID to confirm their identity.

If an AFLAC (supplemental insurance) request, (this typically involves an EDS visit), you are only required to provide a copy of the Physician's Dictation. This is normally 4-5 pages so it falls within our 5 pages free parameter. (Over 5 pages we charge \$.50/page).

If the patient is requesting the information for a Dr's appointment, you will pull the abstract (H & P, D/C, labs, Radiology, EKGs). If a Continuation of Care (COC), there is no charge.

2. ROI Messages Form

---

Caller's Name \_\_\_\_\_ Patient's Name \_\_\_\_\_

DOB: \_\_\_\_\_ Info Needed: \_\_\_\_\_

Fax # \_\_\_\_\_ Phone # \_\_\_\_\_

Caller's Name \_\_\_\_\_ Patient's Name \_\_\_\_\_

DOB: \_\_\_\_\_ Info Needed: \_\_\_\_\_

Fax # \_\_\_\_\_ Phone # \_\_\_\_\_

Caller's Name \_\_\_\_\_ Patient's Name \_\_\_\_\_

DOB: \_\_\_\_\_ Info Needed: \_\_\_\_\_

Fax # \_\_\_\_\_ Phone # \_\_\_\_\_

Caller's Name \_\_\_\_\_ Patient's Name \_\_\_\_\_

DOB: \_\_\_\_\_ Info Needed: \_\_\_\_\_

Fax # \_\_\_\_\_ Phone # \_\_\_\_\_

Caller's Name \_\_\_\_\_ Patient's Name \_\_\_\_\_

DOB: \_\_\_\_\_ Info Needed: \_\_\_\_\_

Fax # \_\_\_\_\_ Phone # \_\_\_\_\_



### 3. ROI Invoice for Release of Medical Record

---

Type in what type of request you're doing. Example: Physician, Workers comp, Patient, Name of local physician.

Document the reason for the request. Example: Continue of Care, Workman's Compensation, Personal, Legal, etc.

When you are charging for records you require prepayment. This means you will **not** print the chart from RIMAGE. You will select **only** the Cover Letter and Invoice to the send. You will need to select the Output Destination to where you want these two documents to print. Print the cover letter.

The INVOICE will have our organization's Tax ID # on it. The payer will need to know this information.

Document the method of release, via fax or via mail.

## Great Plains Regional Medical Center

# EMPLOYEE PERFORMANCE REVIEW

Employee Name \_\_\_\_\_

Employee ID \_\_\_\_\_

Date of Hire \_\_\_\_\_

Date of Evaluation \_\_\_\_\_

Position \_\_\_\_\_

Department \_\_\_\_\_

Type of Rating  Annual Evaluation  On-Boarding Evaluation

**Goal Evaluation:**

Rate employee performance in each of the following categories by using the following scale.

- 1 – Unacceptable: Result was more than 3% below the target; performance improvement plan required
- 2 – Did Not Meet Goal: Result was 1-3% below target
- 3 – Met Goal: Result met the target
- 4 – Exceeded Goal: Result was 1-3% above the target
- 5 – Exceeded Goal: Result was 4% or more above the target

Goal 1:	Result:	Ranking

Goal 2:	Result:	Ranking

**Total of Rankings:** \_\_\_\_\_

Comments/Feedback: (employee)

---



---



---

Comments/Feedback: (supervisor)

---



---



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**Next Year Goal Development:** *(use additional sheet if you form more than two (2) goals)*

Supervisor and employee are to work together to complete the following goal development section for the next evaluation year. Each identified goal should include the tools necessary for successful completion. A total of two goals are to be developed for each employee. All goals should be developed with the following key components identified:

**SMART:** S – Specific M – Measurable A – Attainable R – Relevant T – Timely

Goal 1:	Measured by:	Outcome:

Goal 2:	Measured by:	Outcome:

**Position Description Essential Functions Evaluation:**

*Reference the attached position description to identify whether the essential functions of the position were met using the following scale:*

- 1 – Unacceptable: Performance results show serious deficiencies which seriously interfere with attainment of job and performance expectations; 60 day performance improvement plan is required
- 2 – Below Expectations: Performance results show inconsistent achievement of job performance and position objectives, 90 day performance improvement plan is required
- 3 – Met Expectations: Performance results show consistent achievement toward meeting established performance expectations as identified in the position description
- 4 – Exceeded Expectations: Performance results exhibit overall high performance, routinely goes beyond what is expected in order to substantially surpass all key performance expectations
- 5 – Exceptional Performance: The highest possible performance rating for employees who consistently exceed expectations on all performance rating factors

**Total Points from Position Description Essential Functions Evaluation:** \_\_\_\_



**Performance Evaluation  
Acknowledgement**

By signing below, I acknowledge that I have received my performance evaluation. I also acknowledge that I have reviewed my position description with my supervisor.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Print

\_\_\_\_\_  
Supervisor Signature

# Welcome to Great Plains Regional Medical Center

## HIM Department Overview for New Employees



# Welcome to Health Information Management

## AKA Medical Records

Our MISSION is to...



Provide the kind of healthcare we would want for ourselves and our families, in partnership with those we serve.



Value Statement...

We are committed to:

- Building relations based on trust, honesty, cooperation , and teamwork
- Being a valued, contributing, and responsible member of the region
- Providing care to all
- Developing innovative ways to reduce costs, while striving toward continuous improvement in quality care

## History of HIM

In 1928, the Association of Record Librarians of North America was organized under the sponsorship of the American College of Surgeons.

It was originally called medical record science and members of the profession were called medical record librarians.



The logo for AHIMA, consisting of the letters 'AHIMA' in a bold, sans-serif font, centered within a solid black rectangular background.

The professional association is now known as American Health Information Management Association (AHIMA). In 2000, an updated professional definition for HIM was completed.

It reads...



## AHIMA

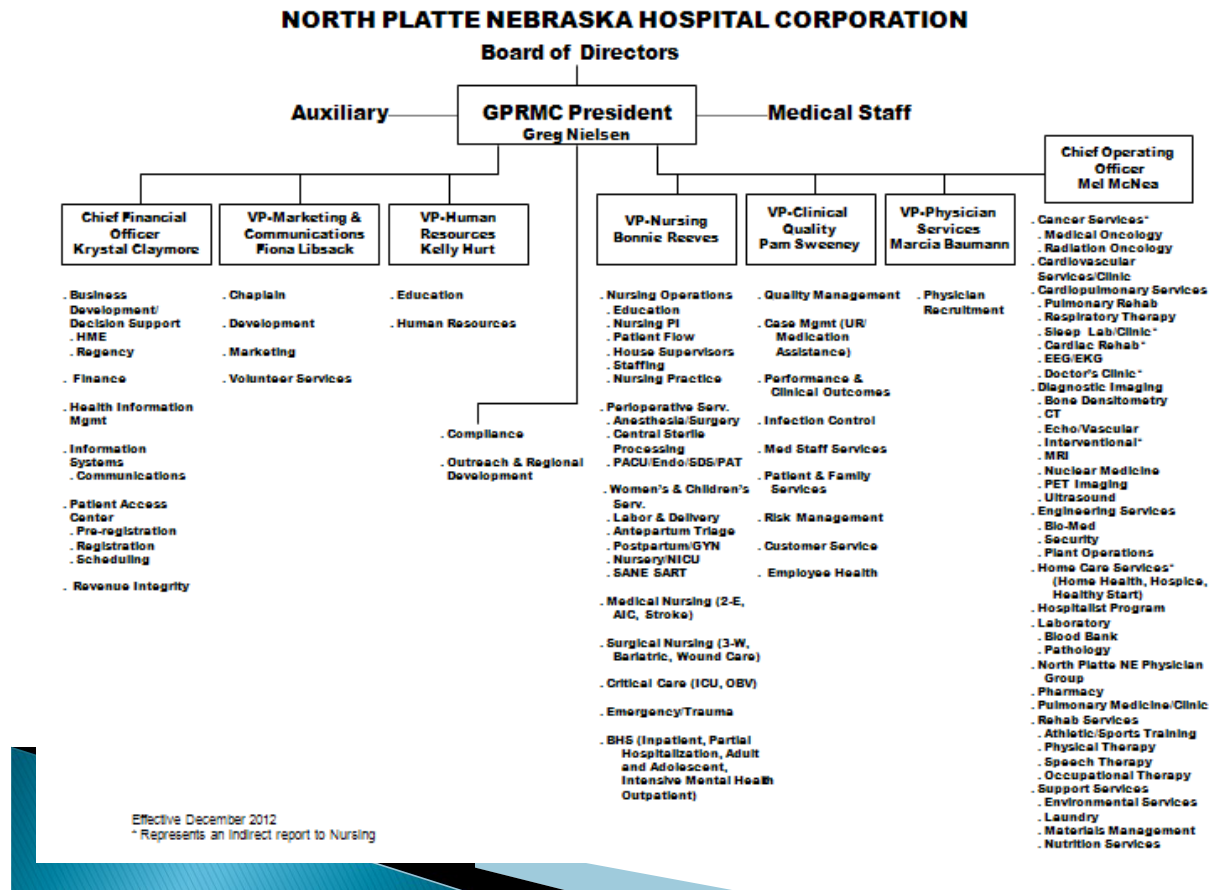
“Health information management improves the quality of healthcare by ensuring that the best information is available to make any healthcare decision. HIM professionals manage *healthcare data* and *information resources*. The profession encompasses services in planning, collecting, aggregating, analyzing, and disseminating individual patient and aggregate clinical data. It serves the health care industry including: *patient care organizations, payers, research and policy agencies, and other healthcare related industries.*”



## Overview of AHIMA Code of Ethics

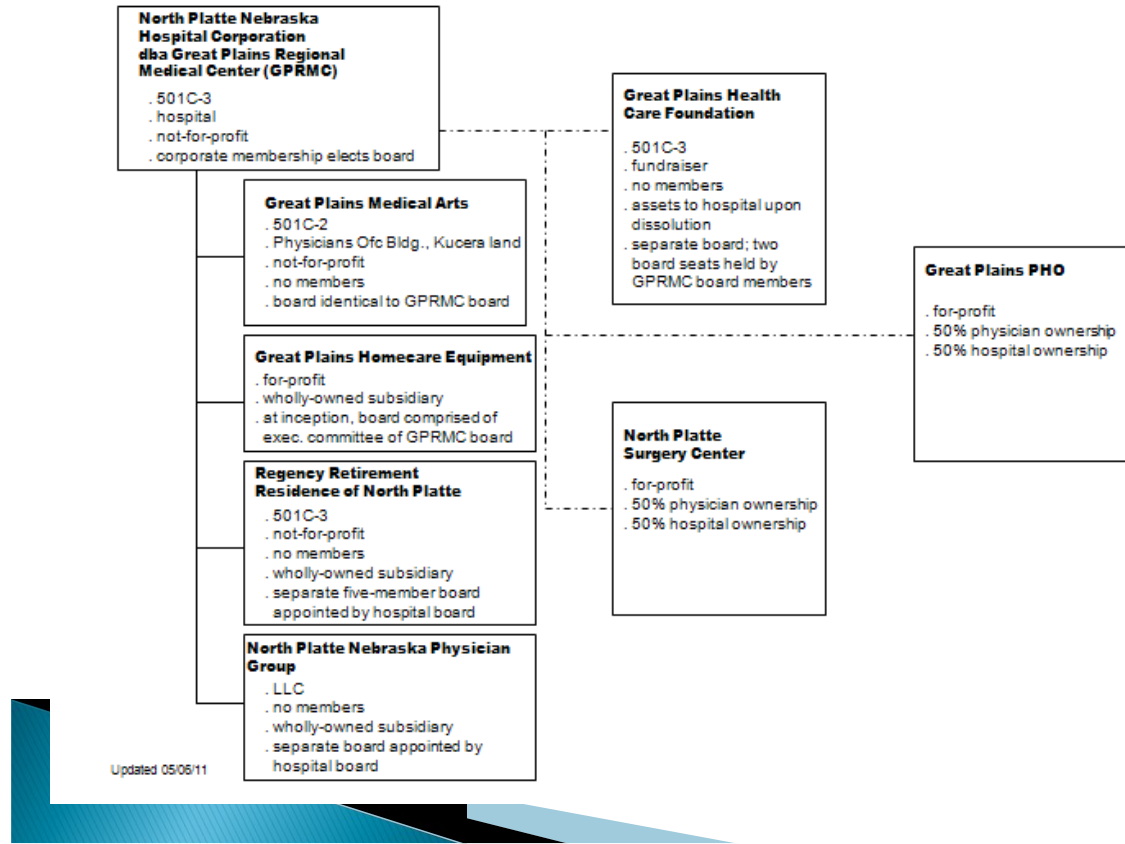
- ▶ Protect all confidential information to include: personal, health, financial, genetic, and outcome information.
- ▶ Engage in social and political action that supports the protection of privacy and confidentiality.
- ▶ Protect the confidentiality of all information disclosing only information that is directly relevant or necessary to achieve the purpose of disclosure.
- ▶ Put service and the health and welfare of persons before self-interest.







**CORPORATE STRUCTURE**



# Job Description

1. Interpersonal Skills
2. Critical Thinking
3. Procedures
  - A. Specific to Release of Information (ROI)
  - B. Specific to Chart Completion
    - 1) Equal Access (EA)
    - 2) Inpatient Records Analyst
    - 3) Outpatient Records Analyst
  - C. Specific to Scanners

## Interpersonal Skills

- Communicates effectively and professionally.
- Models the organization's mission and values.
- Demonstrates courtesy, diplomacy and tact with internal and external customers.
- Displays a professional image with appropriate dress code.
- Demonstrates punctuality in arrival/departure times.



## Critical Thinking

- Takes a systems approach to problem solving and process improvement.
- Effectively adjust to change in a positive manner.
- Performs job functions on site with regular attendance.
- Demonstrates proficiency in all HIM technician policies and procedures.



## Procedures

- Demonstrates competencies established by the Clinical Data Repository Manager.
- Completes orientation training.
- Demonstrates commitment to continual learning, growth, and development.
- Follows hospital & department rules, policies & procedures, as well as applicable laws and standards.

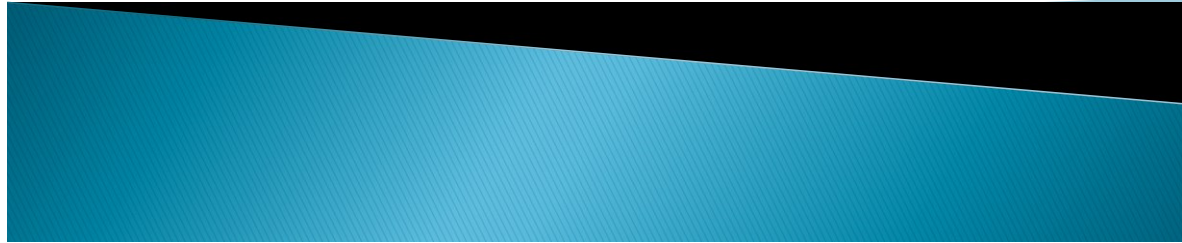


## Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is a law establishing national standards for privacy and security of health information.

**Privacy** is the right of an individual to be left alone.

**Confidentiality** carries the responsibility for limiting disclosure of private matters.



## Release of Information (ROI)

### Responsibilities:

- Timely response to release requests.
- Understanding of what constitutes a valid authorization requesting ROI .
- If valid, that the specific information is copied and sent.
- If invalid, the authorization is returned to requestor and documented in the computer.



## Equal Access

- ▶ Demonstrates the ability to pull deficient charts per physician requests.
- ▶ Demonstrates the ability to check for untranscribed transcription in DVI.
- ▶ Understands responsibility for mailing all charts for completion by any physicians or medical students who left the area with incomplete charts.
- ▶ Understands responsibility for training physicians, PAs, and medical students on how to access the EMR and e-sign.





## Inpatient Records Analyst

- Demonstrates the ability to assign a deficiency to a physician.
- Demonstrates the ability to assemble incomplete charts and how to route them.
- Understands responsibility for confirming that all H & Ps are accounted for.
- Demonstrates the ability to run the discharge register logs for Inpatient, MED, and SURG.



## Outpatient Analyst

- Demonstrates the ability to automatically log all discharged OPS, SPAT, DRCL, OFC, and OBV accounts.
- Demonstrates the ability to assign a deficiency to a physician.
- Demonstrates the ability to run the discharge register logs for OPS, SDS, and EDS.
- Recognizes the different departments that need to be contacted for missing physician orders.



## Procedures Specific to Scan Techs

- ▶ Demonstrates the ability to prep, scan, perform quality review, and upload medical records and loose slips in the legal EMR software system.
- ▶ Demonstrates the ability to event date Advanced Directives.
- ▶ Demonstrates what to do with physician orders with WO or written by medical students or APRN which must be signed by the author.
- ▶ Demonstrates the ability to do weekly maintenance on the scanner.



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