

Component IV: Systems

Module C: Health Care Trends

Topic 2: Health Information Management

I. Statement of Purpose

To provide an increased understanding by the learner of the impact of health information technology in the ambulatory care setting as well as the organizational responsibility for the protection of the individual's private health information.

II. Terminology

1. ANA: American Nurses Association
2. Nursing Informatics: a specialty that integrates nursing science, computer science, and information science to manage and communicate data, information, and knowledge in nursing practice (ANA 2001)
3. EHR: Electronic Health Record
4. CPR: Computerized Patient Record
5. NIDSEC: Nursing Information and Data Set Evaluation Center-program established by the ANA to develop standards to support nursing practice documentation
6. HL7: Health Language 7-an accepted industry standard for messaging in healthcare focusing on clinical and administrative data.
7. NMDS: Nursing Minimum Data Set-includes the data elements that must be collected by all nurses for all patient encounters across all settings
8. UACDS: Uniform Ambulatory Care Data Set
9. Safeguards Principle: provides for trust in the electronic healthcare domain by requiring sufficient safeguards to protect private health information
10. PHI: Private Health Information
11. OCR: Office for Civil Rights
12. PHR: Personal Health Record-a tool that the consumer can use to become a more active participant in their healthcare
13. HIE: Health Information Exchange-a sharing of information across organizations within a region

III. Performance Standards

1. Spell and define key terms
2. Describe how health information technology is utilized in the ambulatory care setting and the advantages of this type of health information management.
3. Identify the regulatory requirements for utilizing an electronic environment for health information storage.

IV. References

1. Goldstein, M.M., Blumenthal, D. (2008) Building an Information Technology Infrastructure, *Journal of Law, Medicine & Ethics*, Winter 2008, 709-715.
2. Hilestad, R., et al, (2005) Can Electronic Medical Record Systems Transform Health Care? *Potential Health Benefits, Savings and Costs*, 24(5), 1103-1117.

3. Laughlin, C.B., (2006) Core Curriculum for Ambulatory Care Nursing, Second Edition, AACN, Pitman, NJ.
4. Meyers, D., Quinn, M., Clancy, C.M. (2011) Health Information Technology: Turning the Patient-Centered Medical Home from Concept to Reality, *American Journal of Medical Quality*, 26, 154-156.

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation
Objective 1 Spell and define key terms <ol style="list-style-type: none"> Review the terms listed in the terminology section. Write down the correct definition or organization identified by the acronym. 	<p>Explain how each term is related to the topic of Health Information Management</p>
Objective 2 Describe how health information technology is utilized in the ambulatory care setting and the advantages of this type of health information management <ol style="list-style-type: none"> Utilization: <ol style="list-style-type: none"> Understand the health information goals of their organization. Utilizes an overwhelming amount of technology to provide care in the outpatient setting. Utilized in clinical practice, administration, education and research. Used for scheduling, ordering and retrieving laboratory results, ordering and charting medications, receiving and scanning reports from outside the organization into the electronic health record, documenting the care that is provided, providing alerts regarding patient care as providing a standardized format for substantiating claims for payment The standardized data set used for this purpose is UACDS; it provides for continuity and uniformity across the multitude of ambulatory care settings. Five purposes that documentation must serve are: patient care, research, legal proceedings, accreditation and licensing and reimbursement. Advantages: <ol style="list-style-type: none"> Involves the exchange of health information into the electronic environment Facilitates transparency and sharing of information Viewed by some as a key component to health care reform Utilized by consumers, providers, payers, insurers and other groups with an interest in health and health care Overall goals of moving health information into an electronic format include: <ol style="list-style-type: none"> Improve the quality of health care and enhance accessibility Prevent medical errors Reduce healthcare costs Improve administrative processes 	<p>Read the section in the Core Curriculum for Ambulatory Care Nursing on Informatics</p> <p>Discuss the different levels of acceptance by physicians, clinical staff and patients when transitioning to an electronic health record in your organization? Has this process been fully incorporated? Why or why not?</p> <p>Describe how the advantages of an electronic health record have made a difference for clients in your care setting. Cite the example with the greatest impact to the patient's outcome.</p>

<ul style="list-style-type: none"> e. Limit paperwork and redundancy in the healthcare environment C. Electronic Health Record or computerized patient record <ul style="list-style-type: none"> 1. Provides for accessibility and continuity of care by system users 2. Advantages of the electronic health record include: <ul style="list-style-type: none"> a. Documentation of all care provided, including that provided through telenursing b. To provide for continuity of care across all physician specialties or testing sites linked within the system c. To document diagnoses to support treatment provided d. To provide reminders for health maintenance e. To allow for trending of results f. To provide for uniform data entry g. To standardize coding systems to facilitate billing and insurance 	
<p>Objective 3 Identify the regulatory requirements for utilizing an electronic environment for health information storage</p> <ul style="list-style-type: none"> A. Developing health policy: <ul style="list-style-type: none"> 1. The Safeguard Principle is supported by the HIPAA Privacy Rule. 2. Must provide adequate technical, physical and administrative safeguards to protect protected health information (PHI) 3. Responsibility of the organization to develop a process to secure the location and storage of the health information 4. Provide for sufficient safeguards to prevent technical risks 5. To provide workplace training regarding the Privacy Rule. 6. Office for Civil Rights <ul style="list-style-type: none"> a. Numerous protections for the individual. b. In the National Network for the Privacy and Security Framework for Electronic Exchange of Individually Identifiable Health Information in a Networked Environment. http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/healthit/safeguards.pdf B. Evaluating the electronic healthcare environment: <ul style="list-style-type: none"> 1. To maintain health information 2. Evaluate the suitability of the software to the organizational needs 	<p>Discuss factors related to safeguarding protected health information that an organization must consider when adopting an electronic health information system</p> <p>Provide three examples where there was or could have been a breach in the privacy of health information in the electronic environment. What was the impact of these breaches and what steps were or could be taken to prevent future recurrence?</p>

<p>3. Meets industry standards for messaging, minimum data sets, standardized language, documentation, decision support and privacy and confidentiality http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_015861.pdf</p> <p>C. Trends:</p> <ol style="list-style-type: none">1. Broaden the use of health information technology2. Includes the personal health record (PHR)<ol style="list-style-type: none">a. Allows for individuals to be more active participants in their own healthcareb. Allows for information from monitoring devices to be receivedc. Allows for documentation by the patient for appointments made, referrals, medication refills and access to reports derived for insurance claimsd. Limited to viewing information only allowed by the provider, not giving free access to the medical record to the patiente. Allows for a sharing of information across organizations within a region or communityf. Improved decision-making at the point of service	
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