

Electronic Records:



What You Need to Know

Amy Brugge, EdD, ATR, ATC
CAATE Accreditation Site Visitor
MATA Governmental Affairs Chair

Documentation of patient care is a professional standard for athletic trainers and all health professionals. However, today's documentation systems are evolving beyond paper-based systems or dictations transcribed by a health information management professional. The following serves describe advancements in health information technology and electronic records solutions.

Background

The American Recovery and Reinvestment (ATRA) Act of 2009 included federal legislation to advance the use of electronic records in the U.S. healthcare system. The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 sought to establish programs to advance the adoption and implementation of electronic records to promote safety and efficiency in healthcare while further strengthening privacy and security regulations for electronic exchange of health information. This key piece of legislation created a federal certification process for electronic health records through the Office of the National Coordinator (ONC) for Health Information Technology and incentive programs for the adoption and meaningful use of certified electronic health records through the Centers for Medicare and Medicaid Services (CMS).

Types of Electronic Records Systems

An assortment of electronic record solutions exist and the following definitions serve as a starting point to understanding the variability in system types.

- **Injury Surveillance System** – an electronic information system intended to track and collect injury data in an organized fashion for research purposes, but is not intended to exchange patient information with other clinical practices or providers.
- **Electronic Medical Record (EMR)** – an electronic record system that is limited in use to **ONE** health care organization and is not capable of electronic exchange and interoperability with electronic record systems at other clinical practices.
- **Electronic Health Record (EHR)** – an electronic record system that has earned government certification through independent testing for electronic security regulations, interoperability standards, and health information exchange **ACROSS** health care organizations.
- **Personal Health Record (PHR)** – an electronic record system that has earned government certification through independent testing for electronic security regulations, interoperability standards and health information exchange, is capable of drawing information from multiple sources, and is **CONSUMER CONTROLLED**.

- **Patient Portal** – a means for allowing secure patient access to his/her health information electronically; can occur with an EMR or an EHR.
- **Academic Electronic Health Record (AEHR)** – an electronic record system that does not contain “live” patient data and is used to replicate an EHR experience when training health professionals.

Certified Health Information Technology (IT) Products

Since 2011, electronic records vendors have been able to voluntarily seek government certification for products through an accreditation process administered by the Office of the National Coordinator (ONC) for Health IT. Certified health information technology products undergo testing to demonstrate compliance with data, vocabulary, and privacy/security standards to enable interoperability between systems for secure and accurate health information exchange. The testing process is carried out by an ONC-Approved Accreditor. The resulting certification indicates that the health IT product is compliant with current government standards, may be used to attest to Meaningful Use objectives set by CMS and is capable of interoperability and information exchange with other certified-EHRs.

A public database is available to health IT product consumers from the ONC at <http://oncchpl.force.com/ehrcert>. This database may be searched by product name, vendor name, or by the certified health IT product list number. Products not listed in this database are not certified-EHRs and may not be capable of interoperability and information exchange with other electronic record systems.

Why Does Interoperability & Health Information Exchange (HIE) Matter?

Health information exchange (HIE) is the ability to transmit healthcare information electronically between disparate information systems while maintaining accuracy of the information being exchanged. Interoperability across record systems is foundational to enhancing quality patient care and safety, decreasing cost and improving efficiency in the healthcare system, executing computerized provider order entry (CPOE), and creating an interconnected knowledge-based network of health information systems.

As federal expectations around HIE continue to expand in the years ahead, the athletic trainer’s ability to communicate with other health professionals via HIE will be vital. The secure electronic exchange of basic patient information (medications, allergies, immunizations, problem lists, existing diagnoses, care plans, etc.), as well more advanced exchange operations, such as electronic transmission of imaging/lab results and submission of surveillance data to public health registries, will become an expectation in the U.S. healthcare system.

Collaboration When Adopting & Implementing an Electronic Record

Pricing for certified-EHRs and EMRs may vary from completely free of cost to a significant and even on-going financial investment. Prior to adopting and implementing an electronic records solution, it is essential to define the needs of the clinical practice, investigate existing options available at the organization, and possibly consult with a health information management professional. Athletic trainers who practice in a school-based setting may find it helpful to collaborate with a health services department or the school’s nurse to examine if needs may be met through shared adoption of an electronic system across providers. If the athletic trainer functions in an outreach model to a school setting, it is prudent to meet with health IT personnel at the practice to determine if the existing clinic/hospital records system may be extended to patients at the school, as opposed to electing adoption and implementation of a separate records system for patient care at the school.

For more information on considerations when selecting an electronic records system for clinical practice, see the *Selecting an Electronic Records System* resource from NATA.

Visit nata.org for more information on Practice Advancement.