Document and Data Integrity in the Legal Health Record

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Outline

- What’s the Buzz?
- The Issues! (and why do we care?)
- The Legal Health Record – Importance of Data and Document Integrity
- Understanding the Level 3 EDMS
- Role of Information Governance
- Moving Forward
A Quick Poll

• Paper?
• ROI Cost?
• Amendments?
• Transcription?
• Productivity?
• The Story of the Patient?
Let’s Get REAL!!

CAN WE TALK?

Joan Rivers
American Television Personality
Born 1933
Current EHR Environment

• In our care facilities.....
  • Many clinicians and HIM/CDI professionals are highly dissatisfied with the flow of information

• Adequate workflow is not present in big box vendor systems to support necessary documentation functionality

• Many decision makers who are selecting “EHR systems” lack knowledge of document workflow, health information management and clinical documentation requirements
## HIM (Lack of?) Participation in EHR Selection & Implementation

Do you feel HIM is involved in the EHR implementation at your facility?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
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<tbody>
<tr>
<td>Involved at the appropriate level and amount</td>
<td>50.0%*</td>
</tr>
<tr>
<td>Less involved than desired</td>
<td>45.4%</td>
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<tr>
<td>Overly involved -- others need to share the workload</td>
<td>4.6%</td>
</tr>
<tr>
<td>Other (please specify)</td>
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*This number decreased 10% since 2014!

Source HIM Briefings 2015 EHR Benchmarking Survey
Another bit of discouraging research……..

60% of the respondents of the 2015 HCPro (Fortis) EHR Benchmarking Survey believe that the EHR is causing quality of documentation issue to stay the same or have gotten worse.

The worse news……..

This is consistent with 2014 findings!
Practices dislike EHR functionality and cost

Q: If you are planning to switch EHR systems, which factors are influencing your decision?

- System functionality: 67%
- Cost: 48%
- Poor customer service: 33%
- Company reputation: 19%
- Platform of software (server vs. cloud): 18%
- Lack of certification for Meaningful Use 2: 16%
- Other: 19%

Source: 2014 EHR Survey; MPI Group/Medical Economics

67% of respondents are dissatisfied with system functionality
Use of Internist’s Free Time by Ambulatory Care Electronic Medical Record Systems,” a team led by Clement J. McDonald, MD

- 411 physician respondents
- 61 different EHRs used
- 9 EHRs used by 20 or more docs

- 59.4% said they lost time after moving to an EHR from paper
- 63.9% said note writing took longer with an EHR
- 33.9% said it took longer to review EHR charts than paper
- 32.2% were slower to read other clinicians’ notes

http://thehealthcareblog.com/blog/2014/09/22/ehr-design-its-a-matter-of-time/
Why Is Data and Document integrity So Important?

- Quality/Utilization
- Patient Care
- Research
- Education
- Reimbursement
- Legal Defense - Risk Mitigation
- Certificate of Need (Planning)
- Marketing
- Budgeting/Resources
- Historical Documentation
- Compliance
- Physician Credentialing
- Contract Negotiation
Symptoms of a Sick Record

• Cut and paste proliferation

• Out of sequence and duplicative documentation

• Docs phone texting clinical colleagues to avoid documenting

• Inadequate choices in templates (generic terms)

• Case Mix Dropping
Symptoms of a Sick Record (Cont.)

• Carry over of historical conditions/meds

• Conflicting consultations

• Poor grammar, spelling, and syntax

• Lack of print control (is this the latest version, the original document?)

• Can’t tell the story of the patient
Impact of Poor Documentation?

• Joint Commission - Sentinel Event 54 warnings
  http://www.jointcommission.org/sea_issue_54/

• OIG Fraudulent Billing Risk Alerts

• Patients demanding amendments/corrections

• Heightened legal activity and risk

• Slowed productivity (particularly coding)
Impact of Poor Documentation? (Cont.)

• Medical errors, patient morbidity/mortality
• Increased costs to patients and organizations
• Compliance issues and rejections
• Lowered case mix/reimbursement
• Clinician dissatisfaction
• Expenses – i.e. cost of professional scribes, outsourced Coding/CDI using excessive time
Does this impact patient care?

• Next time you enter the hospital.....
• When you are trying to help a parent through a severe illness......
• If you need to change doctors....
• If you have had your medical identity stolen...
• If you are trying to get a bill paid.....
• If you have to manage an HIM department!
Moving Out of the HYBRID state

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_H___ ______ ______ ___L___
How Did This Happen?? Being on the Bleeding Front....

- Automation prematurely implemented due to Meaningful Use caused rush of implementation and inadequate design of workflow in so-called EHRs (HIS)

- (Electronic) Hybrid fragmentation deteriorating ability to provide care and manage post discharge records efficiently and effectively

- ICD-10-CM/PCS did not have adequate preparation or support from clinicians and vendors

**BOTTOM LINE.....Document Integrity and therefore Data Integrity are at Risk**

What are your personal/family stories?
Which EHR Are We Talking About?

- **CIS** ............... (clinical information system)
- **CCR** ............... (continuity of care record)
- **CDR or CDW** .... (clinical data repository / warehouse)
- **CPOE** ............. (clinical physician order entry)
- **CPR** ............... (computer-based patient record)
- **EDMS** ............. *(electronic document management system)*
- **EHR** ............... *(electronic health record - generic)*
- **EIS** ............... (electronic information system)
- **ELMR** ............. (electronic legal med record or episodic longitudinal med record)
- **EMR** ............... (electronic medical record)
- **EPR** ............... (electronic patient record)
- **LHR** ............... *(legal health record)*
- **HIM** ............... (health information management)
- **HIS** ............... (health information system)
- **eHRM** ............. (electronic health record management)

No wonder there is confusion in the industry!
Poor Design of the EHR Simply Automates Current Dysfunction
Understanding Clinical Systems and Their Relationship to HIM

• Today’s clinical systems are developed by both large core HIS vendors and smaller ‘best of breed’ vendors

• They are dominated by physician and other clinician centric workflows appropriately designed for the active patient care delivery process

• There is lack of functionality to support health information management archival, operational, or administrative processes

As a result, clinical systems which are not integrated with an electronic document management system (EDMS) tend to actually hinder efficient HIM processing by creating disjointed or duplicate activities and negatively impact physician and facility efficiency and reimbursement
Examining the Dual EHR Landscape

Acute Clinical Care Record

• Discrete Data Driven
• Dynamic
• Template Based
• Input Oriented
• Longitudinal
• Version Based
• Fragmented Sources

Discharged Legal Health Record

• Document Driven
• Stable
• Form/Report Based
• Output Oriented (display or print)
• Episodic
• Complete Story
The Importance of the Level 3 EDMS model

Figure 1.3  Electronic document management system model, level 3

- 100% optimized functionality
- Dedicated EDMS software with workflow integration
- Full COLD interfaces from all systems
- Scanning functionality
- Reporting functionality
- Full legal health record support

Examples of COLD feeds

Defining Document & Data Integrity

Document Integrity:

• The process of ensuring all paper and electronic documents are received and included into a single medical record for each episode of care and are equally accessible through a single request, and purged with a single function.

Data Integrity:

• 1. The extent to which healthcare data are complete, accurate, consistent and timely.

• 2. A security principle that keeps information from being modified or otherwise corrupted either maliciously or accidentally; also called data quality.

Document and Data Integrity Mean...

• All the documents expected to be present have been received (Reconciliation)
• All the documents are easily accessible from a single location (no more hunt and pick.
• All the documents represent the only ‘original’ and are persistent when viewed for archive purpose.
• Each document is a static piece of documentation unique to the discharged episode of care.
• The documents tell the ‘story’ of the record for the complete episode of care.
• Documents are able to be fully purged from a single source
Document and Data Integrity Means....

- The content of the document is legible
- The printed or displayed output matches the input format for each piece of documentation
- Modifications and error corrections are clearly visible to the end user when reading the record
- All documents clearly display the author, authenticator, and the date/time of entry
- Longitudinal data or historical data is distinct from episodic data
- There is minimal redundancy in data and conflicting documentation data is identified and resolved
GROUP EXERCISE

Admitting the issue exists........and what steps are we taking to resolve?
A Quality Progress Note

*Think on Ink for daily progress notes/visits:

• As the caregiver.....You are thinking in terms of differential diagnoses and should say: “I think the patient has the ________ conditions if I could do this test, or talk to this consultant, or…….”

• THEN, “Based on __________ results / observation / review / discussion(s); I now have __________ NEW information, and my plan is to do __________.”

• All notes, and episode of care should STAND ON OWN

• Don’t document what wasn’t done & don’t omit what was done

*Think on Ink –phrase credit – Dr. James Kennedy
HOW can the HIM Professional help this situation?
What Is Information Governance?

• *AHIMA defines IG as “An organization-wide framework for managing information throughout it’s lifecycle and for supporting the organization’s strategy, operations, regulatory, legal, risk, and environmental requirements.”

*AHIMA Infographic
But *HOW* do you operationalize this “framework”?
What Roles Do HIM Professional Serve in IG? *

• Establish **policies**
• Determine **accountability** for managing information
• Promotes objectivity in establishing robust **processes**
• Protects information with appropriate **controls**
• **Prioritizes** investments

*AHIMA Infographic*
Core Functions

• Chart and Master Patient Index Reconciliation
• Chart Prep (for scanning and hold)
• Analysis (prior to coding!)
• Coding & Abstracting
• Release of Information
• Archive, Retention, and Purge
There's another way to go!
Top Recommendations for Improving Quality of Documentation

• Improve Documentation Creation Integrity
  • Reduce/Eliminate Copy & Paste
    • Use provenance (source of origin) differentiation as control to avoid ‘note bloat’
  • Reduce/Eliminate carry forward of historical documentation to avoid patient safety risk
    • Use provenance (source of origin) differentiation as control

• Utilize Master Document & Master Data Dictionary
  • Avoid redundancy and definitional conflict
EHR Documentation 3R’s and 5C’s of Document & Data Integrity

1. RELIABLE
2. RELEVANT
3. RISK MITIGATED

1. Clear
2. Concise
3. Compliant
4. Complete
5. Concurrent/Chronologic
Impact of Poor Documentation?

• Joint Commission Sentinel Event 54 warnings
• OIG Fraudulent Billing Risk Alerts
• Patients demanding amendments/corrections
• Heightened legal activity and risk
• Slowed productivity (particularly coding)
• Medical Errors/Patient Morbidity/Mortality
• Increased Costs to Patients (ROI) and organizations
• Compliance issues and rejections
• Lowered Case Mix/Reimbursement
• Clinician dissatisfaction
The Time To Act is NOW ……..
Let’s Start Talking The Same Language When It Comes to Documentation!

TRANSCRIPTION – A key to medical language integrity!!
The Levels of EHR Integrity Leading to Interoperability

• The Data Level
• The Document Level
• The Episodic Record Level
• The Longitudinal Record Level Within a System (Enterprise)
• True Interoperability Across Multiple Systems
Improvements in Documentation Lead To......

• Improved Interoperability of data (via documents)
• Clean mergers of organizations
• Improved productivity – viewing efficiency
• Compliance with Record Retention programs
• Building a good foundation for advanced functionality i.e. Computer Assisted Coding, ICD-10-CM, Big Data Monitoring
• Better patient care (i.e. Safety, Resource reduction)
In Summary-Review of Good Documentation Standards

- Document each note so that it can stand alone
- Avoid Note Bloat: Do not pull older notes or findings forward automatically or copy and paste – they should remain as the source reference file

- Think on Ink-
  - If THIS test were done, I can rule out/in xxxx
  - Based on yyyyy results/observation/review, my plan is to do zzzzz

- Documentation 5 C’s principles:
  - Concise, Complete, Compliant, Clear, Concurrent/Chronologic

- Document Integrity 3 R’s principles:
  - Reliability, Relevancy, and Risk Mitigation

- Monitor through 5 point audit
Final Tips for Success

• Start with a **Forms Inventory and Forms Committee**
• Report EHR issues as a **Quality Indicator**
• **Prevent**, don’t just manage problems
• **Don’t Isolate** yourself or the HIM Department
• **Don’t be Afraid to Take a Seat at the Table**
• Get **Back to Basics**, but use Automation to your advantage
• **Don’t try to take over the IT Department** – **proudly manage** the HIM Department and the LHR
• **Keep Aware of AHIMA and CSA initiatives**
The Bottom Line

Step Up to the role of “Legal Custodian of the Record”

Information Governance can only be Operationalized through YOU!
What We Know For Sure

In time of uncertainty and challenge.....
........The only constant is change!

But HOW you deal with that change........
..............Is what will determine your success!
Hitting the gym to release stress is not nearly as effective as hitting the people that caused the stress to begin with.
Thank You! Questions??

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Download the white paper entitled “Forging a Path to the True Legal Health Record” by Darice M. Grzybowski, MA, RHIA, FAHIMA, H.I. Mentors, LLC

Available on Amazon .com and at AHIMA (member discount and e-books also available):
https://www.ahimastore.org/SearchResults.aspx?SearchString=grzybowski

More IG Resources

- [http://www.ahima.org/~/media/AHIMA/Files/HIM-Trends/IG_Infographic.ashx](http://www.ahima.org/~/media/AHIMA/Files/HIM-Trends/IG_Infographic.ashx)
- [http://www.ahima.org/~/media/AHIMA/Files/HIM-Trends/IG_Benchmarking.ashx](http://www.ahima.org/~/media/AHIMA/Files/HIM-Trends/IG_Benchmarking.ashx)
About Darice Grzybowski, MA, RHIA, FAHIMA
Founder/President H.I.Mentors, LLC (2005)

- 35 years experience in Health Information Management and Clinical Data Management
- AHIMA 2x Triumph Award Winner (2015 Literary Legacy Award), 1994, (Professional Achievement in Advancement of Computerized Records)
- Adjunct Assistant Professor University of IL at Chicago School of Biomedical & Health Information Sciences
- Previous ILHIMA President and Elected Delegate (x2); Recipient IL and Chicago Area Distinguished Member Awards, Award-Winner Top 10 in 2010 – Advance for HIM Professionals recipient
- Member Editorial Advisory Board and Quarterly Contributing Author of HCPro’s HIM Briefings and Electronic Health Record Briefings since 2005
- Previous member HL7 and ASTM 3.11 Standards Taskforces as well as Numerous AHIMA eHIM Practice Brief workgroups
- Professional Member NSA (National Speaker’s Association) with multiple HIMSS, HFMA, AHIMA, ACDIS, etc. speaking experience
- Author “Strategies for Electronic Document and Health Record Management” (AHIMA 2014)