Best Practices in Medical Record Documentation and Completion

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Background

In 1998, AHIMA's 1998 House of Delegates approved a resolution titled "Advocating Quality and Cost-efficient Health Information Documentation Requirements." The resolution cited managing and monitoring the quality of documentation in patient medical records as core functions of the health information management profession. It also stated that documentation is an important, dynamic form of communication that provides a clinical treatment trail for care providers and a historical medicolegal document for use in future patient care, education, research, reimbursement, and other purposes.

In addition, the resolution stated, documentation guidelines should reflect both current practice and modern technology. Availability of tools that provide for electronic capture of patient data and documentation mandates the need for simplified and sensible documentation requirements. And the shift in healthcare to nonacute care environments mandates a need for immediate access to health information and a more rapid and flexible communication and documentation method.[1]

To that end, HIM professionals have developed best practices in medical record documentation. Based upon these and other best practice efforts, AHIMA has developed a list of best practice characteristics and described the process for making improvements. While not exhaustive, this information facilitates and encourages documentation and record completion improvement efforts and the establishment of new best practices.

Characteristics of Best Practice Efforts

These characteristics were adapted from the insights of winners of the Nicholas E. Davies CPR Recognition Award of Excellence.[2]

Shared conviction: Management should demonstrate shared conviction to a given strategy or plan from the top of the organization or department by:

- leading the change effort
- continuity of leadership (long tenures)
- sustained investment in a given strategy or plan, perhaps over a period of years
- delivering what is promised
- devoting time, effort, and resources to process evaluation and change management

Problem resolution: People affected by problems should have ownership and control of problem resolution. Empower process owners to improve their own work environments within acceptable standards and to satisfy the customer.

Champions: Secure "champions" and resources for the change effort. In addition to HIM professionals, champions may include physicians, facility administrators, and other healthcare practitioners. Accomplish this by positively positioning the expertise and value of the health information management services within an organization and by leading and collaborating across disciplinary and organizational boundaries.[3]

Customer service: Use good customer service techniques, including responding to feedback and assessing customer satisfaction. Obtain feedback during focus group meetings, informal gatherings, meetings, surveys, questionnaires, process evaluation, and participation in the change effort.

Innovation: Encourage "Out of the box" and "cutting edge" thinking—and try something new (or something old again). For example, in addition to their traditional responsibilities, utilize transcriptionists and/or coders to translate information into structured (standardized) data. (Universally coded patient data—as opposed to free text—is ideal because it makes each element of patient documentation available for both concurrent decision support and retrospective analysis of practice patterns.) Establish agreement on data standardization across the organization. Then migrate to more structured (standardized) information based on what is essential for care management, rather than attempting to capture all patient information as codes from the outset.[4]

Change management: Because acceptance and adoption of change appear to depend on content and perceived value to the participant, approach any change effort from the perspective of those affected.

Impact assessment: Establish monitors to demonstrate the impact of the change effort, i.e., the number of:

- processes that no longer rely on paper documentation
- physician visits to complete records post discharge
- delinquent and/or incomplete records
- positive feedback from customers
- innovations piloted
- improvements in information timeliness and availability
- discontinued unnecessary or redundant processes
- reduction in unbilled accounts due to incomplete records

Simplification: Seek opportunities to simplify and streamline processes to minimize the number of steps to accomplish a task, e.g., to reduce the number of:

- times a physician visits the department to complete records
- times a record is handled to file loose reports
- records coded without complete documentation

Lifelong Learning: Work to ensure that demonstrating lifelong learning and taking responsibility for professional and personal development are inherent in your organization's culture. Apply new knowledge and skills in the workplace and actively seek assistance, education, and resources.

Making an Improvement[5]

The very first step toward improving a process is to understand the process. Often inadequate knowledge of how a process does work, coupled with inadequate knowledge of how a process should work, stand in the way of improving a process. For example, it is not uncommon for management to call upon staff to work harder to overcome a problem in the process instead of carefully examining each step in the process.

Begin by flowcharting the entire process. The individual(s) who perform the task should be directly involved in the flowcharting development. Don't leave out any steps in the process.

Once the flowchart of the process is complete, management and staff should go through the process step by step.

Review the steps in the process for:

1. steps where errors or mistakes occur
2. steps included because of personal attitudes
3. unnecessary steps
4. steps designed to add padding or protection (e.g., double checking, rework, handling work more than once)
5. steps that have a high percentage of variation in their outcomes

Question why each step in the process is performed. Always consider customer needs and concerns; what steps can be eliminated, streamlined, or improved? Decide which changes you can make, implement changes, follow up to see that changes were carried out, and monitor to determine positive or negative impact on the process.

Initial Decision: When should an improvement be made or a best practice be implemented? A need is legitimate if it adds value to the customer, organization/facility, affected area or people, or work environment (without detracting from the other three). Once the decision is made, begin the process of improvement as described by the Associates in Process Improvement.[6]

Aim: Reach an agreement on what is to be accomplished or the aim of your improvement efforts. What are you trying to accomplish? Where does the change/best practice "fit" in the system? Will it have positive impact on the system or success indicators? Is the change customer focused? Which of your customers will benefit from the change? (Customers include but are not limited to physicians, practitioners, employees, administrators, accreditation agencies, and regulators.) Does the improvement opportunity provide value for the time spent?

Current Knowledge: Gain knowledge about the current situation and establish measures of quality. How will you know that a change is an improvement?

Improvement Cycle: What changes can you make or what best practices can you implement that will result in improvement? Increase your knowledge about the situation. Develop and test a change on a small scale. Implement a change.

- Plan: Determine which best practice to implement. (See "Selecting a Best Practice.") What change or best practice will result in the greatest improvement? Who has the resources you need to make the change? Plan to carry out the improvement cycle—the who, what, when, and where. Document questions to be answered and predictions and anticipated changes as a result of the cycle
- Do: Carry out the plan. Collect monitoring data and begin analysis
- Check/study: Complete the analysis of the data. Compare the data to predictions and summarize what was learned
- Act: Determine what changes are to be made and make them. Begin the next cycle

Selecting a Best Practice

Considerations

What works in one environment may not work in another. Therefore, to better ensure a successful outcome, consider these factors when selecting a best practice to implement:

- customer feedback, including but not limited to accreditation agency survey results, complaints, satisfaction survey results, recouped reimbursements, and the number of denied or unbilled claims
- cost
- available resources, including champions, staff time, equipment, and funding
- timing or priorities
- state and federal laws and regulations
- organizational culture
- external forces such as accreditation agency standards, laws, and regulations

Best Practice Sources

To learn about best practices and what worked for others, use the following table of best practices or use AHIMA resources such as:

- annual convention and exhibition
- audio seminars
- publications such as *In Confidence* and the *Journal of AHIMA*
- models and plans
- position statements
- practice briefs
- specialty group newsletters
- state HIM associations
- AHIMA's Web site

Other resources include:

- conventions/conferences—national, state, regional, and local
- HIM trade periodicals and listserves
- networking with peers
- similar situations outside the industry. For example, data quality management and customer identification issues in large commercial databases (e.g., the credit card industry) are similar to those in the healthcare industry. Adapt their best practices to improve your environment

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Notes

1. "Advocating Quality and Cost-efficient Health Information Documentation Requirements." Resolution from the 1998 House of Delegates. *Journal of AHIMA* 70, no. 1 (1999): insert.

2. Metzger, Jane B., Margret Amatayakul, and Ned Simpson. "Lessons Learned from the Davies Program: The First Four Years." *Fourth Annual Nicholas E. Davies CPR Recognition Symposium Proceedings,* July 9-10, 1998. Washington DC: Computer-based Patient Record Institute, 1998.

3. Eichenwald, Shirley, and Linda Frank. "Be a Player: Enhancing the HIM Role in Your Workplace." AHIMA audio seminar, 1999.

4. Metzger, Jane B., et al. "Lessons Learned from the Davies Program."

5. Personal communication with Anita Dorf, 1995.

6. Langley, Gerald, Kevin Nolan, and Thomas Nolan. "The Foundation of Improvement (Parts 1 & 2)." Associates in Process Improvement, 1992.

Table of Best Practices

Best Practices	References
1. Consistent and standardized documentation requirements	
a. Advocate consistent and standardized documentation requirements by working with stakeholders and accrediting and regulatory bodies including but not limited to the Joint Commission, National Committee for Quality Assurance, the Health Care Financing Administration, American Society for Testing and Materials, and HL7.	
i. Elimination of physician attestation requirement.	"HCFA Officially Removes Physician Attestation Requirement." *Medical Records Briefing* 10, no. 8 (1995): 1, 3.

ii. Streamline regulatory activities.

Grzybowski, Darice. "Position Statement—Streamlining Regulatory Activities." *Journal of AHIMA* 64, no. 9 (1994): insert.

iii. Change laws or legislation that requires physician signatures on verbal orders.

Clark, Susan. "To Sign or Not to Sign Verbal Orders." *Journal of AHIMA* 69, no. 5 (1998): 62-64.

2. Innovative, quality, and cost-efficient clinical documentation practices

a. Utilize different authentication and authorship mechanisms depending on available technology.

Brandt, Mary. "Position Statement—Authorship." *Journal of AHIMA* 65, no. 1 (1994): insert.

French, Bill. "Improving the Quality of EPR Documentation through Online Editing and Authentication." *Toward an Electronic Patient Record '98: Proceedings, Volume Two*. Newton, MA: MRI, 1998, pp. 212-214.

"Low Delinquency Rate is Key to Success in Random Unannounced JCAHO Survey." *Medical Records Briefing* 11, no. 1 (1996): 4-5.

Rhodes, Harry. "Practice Brief—Electronic Signatures (Updated)." *Journal of AHIMA* 69, no. 9 (1998): insert.

b. Reduce record completion time frames. The time from patient discharge to record completion should be as short as possible. Develop policies and practices to facilitate completing records in a timely manner.

Berkey, Tim. "Reducing Accounts Receivable Through Benchmarking and Best Practices Identification." *Journal of AHIMA* 69, no.10 (1998): 30-34.

Carrier, Danielle. "Best Practices: What Works?" *Journal of AHIMA* 70, no. 7 (1999): 61-68.

"Director Cracks Down on Delinquent Verbal Order Signatures." *Medical Records Briefing* 13, no. 10 (1998): 3.

MacDonald, Ellen. "Better Coding through Improved Documentation: Strategies for the Current Environment." *Journal of AHIMA* 70, no. 1 (1999): 32-35.

"Survey: Best Medical Record Practices for Reducing Accounts Receivable Days." *Medical Records Briefing* 10, no. 12 (1995): 12. Best Practices References

i. Collect records of discharged patients quickly. For example, have staff make rounds to retrieve records of discharged patients, analyze records in

Bennet, Anna, Estelle Kennedy, and Peggy Looney. "Field Tested: Redesigning the

the evening/night shift to make available more quickly to physicians, or implement concurrent analysis processes.	Indexed Medical Record." *Journal of AHIMA* 69, no. 10 (1998): 72-74. Clark, Jean S. *Ongoing Records Review: A Guide to JCAHO Compliance and Best Practice.* Marblehead, MA: Opus Communications, 1998, pp. 45-51.
ii. Ensure incomplete records remain available to physicians for completion. If needed for other than patient care, have record reviewed in department.	Clark, Jean S. *Ongoing Records Review: A Guide to JCAHO Compliance and Best Practice.*
iii. Establish the physician's preferred appointment day and time to complete records and have them ready at the appointed time.	
iv. Develop equal access system so that all physicians with deficiencies in a record have access to the record.	
v. Apply record completion policies uniformly to all physicians without exception. Neither politics nor revenue should be a factor.	
vi. Withhold resident paychecks or do not allow residents to graduate with incomplete records.	
vii. Use quality improvement techniques to improve record completion timeliness.	
viii. Reduce documentation requirements to those currently required by accreditation agency(ies), federal or state law.	
ix. Monitor and graphically report improvement efforts.	
x. Redesign forms to ensure that they are "user-friendly."	Clark, Jean S. *Ongoing Records Review: A Guide to JCAHO Compliance and Best Practice.* Rhodes, Harry. "Practice Brief—Developing Information Capture Tools." *Journal of AHIMA* 68, no. 3 (1997): insert.

xi. Decentralize record completion; e.g., implement remote computer access and deliver incomplete records to the emergency department, medical staff meetings, and physician lounges (surgery, recovery room, obstetrics, etc.) for completion.	Carroll, Eugene T., Susan Wright, and Cindy Zakoworotny. "Securely Implementing Remote Access Within Health Information Management." *Journal of AHIMA* 69, no. 3 (1998):46-49. Clark, Jean S. *Ongoing Records Review: A Guide to JCAHO Compliance and Best Practice.*
xii. Work with other hospitals in the system/geographic area to make records completion requirements consistent.	Clark, Jean S. *Ongoing Records Review: A Guide to JCAHO Compliance and Best Practice.* Layer, T., and L. Page. "Development of an Interinstitutional Resident Record Completion Policy." *Topics in Health Information Management* 14, no. 3 (1994): 48-56.
xiii. Analyze records for deficiencies on a concurrent basis.	Kirk, Rosemary. "The Inpatient Medical Record Analysis Program." *Medical Record News* (February 1976): pp. 15-19.
xiv. Levy fines, suspend privileges, or otherwise punish physicians who do not complete records in a timely manner.	"Activity Log Supports Physician Suspensions." *Medical Records Briefing* 13, no. 11 (1998): 9. "Benchmarking Survey: Most Hospitals Stick to Traditional Methods for Records Completion." *Medical Records Briefing* 11, no. 1 (1996): 10-11. Clark, Jean S. *Ongoing Records Review: A Guide to JCAHO Compliance and Best Practice.* "Hospitals Find Tough Enforcement of Record Completion Most Effective." *Medical Records Briefing* 10, no. 12 (1995): 10-11. Rogliano, Julia. "Managing Delinquent Records." *Journal of AHIMA* 68, no. 8 (1997): 28-30. "This Month's Idea: Work with Medical Staff Services to Improve Records Completion." *Medical Records Briefing* 12, no. 10 (1997): 12.
xv. Utilize positive incentive programs for timely record completion, e.g., gifts, drawings/raffles,	"Benchmarking Survey: Most Hospitals Stick to Traditional Methods for Records

certificates of recognition, food, record completion events, etc.	Completion." *Medical Records Briefing* 11, no. 1 (1996): 10-11. Clark, Jean S. *Ongoing Records Review: A Guide to JCAHO Compliance and Best Practice.* Mahoney, Mary Ellen, et al. "The Effects of Positive Incentive Programs on Physician Chart Completion." *Topics in Health Record Management* (September 1990): 40-53.
xvi. Reduce reliance on paper-based sources of information to reduce/eliminate routine delivery and maintenance of paper records.	Metzger, Jane B., Margret Amatayakul, and Ned Simpson. "Lessons Learned from the Davies Program: The First Four Years." *Fourth Annual Nicholas E. Davies CPR Recognition Symposium Proceedings,* July 9-10, 1998. Washington, DC: Computer-based Patient Record Institute, 1998.
xvii. Standardize so that what is billed derives exclusively from the electronic documentation to reduce/eliminate release of information for reimbursement purposes, claim audits, and record handling.	Metzger, Jane B., Margret Amatayakul, Ned Simpson, "Lessons Learned from the Davies Program: The First Four Years."
xviii. Streamline medical record completion guidelines.	Devitt, Monica Pappas, et al. "Health Record Completion Guidelines." *Journal of AHIMA* 62, no. 11 (1991): 26-44. "Low Delinquency Rate is Key to Success in Random Unannounced JCAHO Survey." *Medical Records Briefing* 11, no. 1 (1996): 4-5.
xix. Minimize unsigned verbal orders.	Clark, Jean S. *Ongoing Records Review: A Guide to JCAHO Compliance and Best Practice.* "Director Cracks Down on Delinquent Verbal Order Signatures." *Medical Records Briefing* 13, no. 10 (1998): 3. "Low Delinquency Rate is Key to Success in Random Unannounced JCAHO Survey." *Medical Records Briefing* 11, no. 1 (1996): 4-5.
xx. Reduce loose filing backlogs.	"This Month's Idea: Routing Routine Eliminates Loose Filing Stacks." *Medical Records Briefing* 11, no. 11 (1996): pp. 12.

	"This Month's Idea: Tool Helps Director Sort Through Loose Reports." *Medical Records Briefing* 11, no. 10 (1996): 12.
xxi. Allow medical staff to take responsibility for record completion timeliness.	Clark, Jean S. *Ongoing Records Review: A Guide to JCAHO Compliance and Best Practice.* "Records Completion: Force the Medical Staff to Take Responsibility." *Medical Records Briefing* 11, no. 10 (1996): 6-7. "This Month's Idea: Make Record Completion a Recredentialing Factor." *Medical Records Briefing* 10, no. 8 (1995): 2.
c. Utilize new and improved technology for documentation.	
i. Speech recognition to supplement transcription services.	"How Hospital Can Take Advantage of Speech Recognition Technology." *Medical Records Briefing* 12, no. 10 (1997): 8-9.
ii. Develop a standardized format for policies and procedures that are accessible electronically.	"Web Gives Greater Access to Policies and Even Helps Reduce Delinquencies." *Medical Records Briefing* 12, no. 10 (1997): 8-9.
iii. Utilize e-mail to transmit information.	Rhodes, Harry. "Practice Brief—E-mail Security." *Journal of AHIMA* 68, no. 6 (1997): insert. "Is E-Mail a Safe Way to Transmit Patient Data?" *Medical Records Briefing* 13, no. 11 (1998): 6-8.
iv. Implement telemedical record documentation processes.	Fletcher, Donna. "Practice Brief—Telemedical Records." *Journal of AHIMA* 68, no. 4 (1997): insert.
3. Promote complete, current, and quality healthcare information by developing and using appropriate measures and monitors to assess medical record documentation quality	
a. Develop documentation processes that reflect the organization's uniqueness.	
b. Organize an ongoing records review program and monitor its effectiveness using performance improvement techniques.	Bisbee, Walter, and Debra Harris Lillback. "Designing the Integrated Multidisciplinary Record Review." *Journal of AHIMA* 69, no. 6 (1998): 54-60. Clark, Jean S. *Ongoing Records Review: A Guide to JCAHO Compliance and Best Practice.* pp. 1-35, 53-100.

	"Clinical Pertinence Review: Minnesota Facility Develops an Effective System." *Medical Records Briefing* 11, no. 11 (1996): 10-11. Labak, Carol. "Performance Improvement for Documentation." *Journal of AHIMA* 69, no. 9 (1998): 88-90.
c. Streamline medical record completion guidelines.	Devitt, Monica Pappas, et al. "Health Record Completion Guidelines." Johnson, Thomas, and James Pesek. "Reengineering Medical Records: The Dubois Regional Medical Center's Experience." *Journal of AHIMA* 69, no. 3 (1998): 57-59.
d. Educate practitioners and others on the importance of innovative, quality, and cost-efficient clinical documentation practices.	French, Bill. "Improving the Quality of EPR Documentation through Online Editing and Authentication." MacDonald, Ellen. "Better Coding through Improved Documentation: Strategies for the Current Environment." "Teaching Documentation: A Critical Role for HIM Professionals." *Medical Records Briefing* 13, no. 9 (1998): 4-5.
e. Recruit physician to act as liaison to improve documentation.	Wilson, Valerie, Juanita Hammer, and Daniel Washburn. "Physician Liaison Program Brings Improvement." *Journal of AHIMA* 70, no. 2 (1999): 51-52.
4. Plan strategically	
a. Develop an electronic or computer-based health record.	Burgess, Barbara, Karen Wager, Frances Wickham Lee, Robert Glorioso, and Luanne Bergstrom. "Clinics Go Electronic: Two Stories from the Field." *Journal of AHIMA* 70, no. 6 (1999): 42-46. Didear, Kay, and Marcia Kalata. "CPR Success Stories." *Journal of AHIMA* 69, no. 9 (1998): 54-57. French, Bill. "Improving the Quality of EPR Documentation through Online Editing and Authentication." Frohwerk, Art. "Implementing the CPR: A Journey." *Journal of AHIMA* 70, no. 3 (1999): 32-37.

b. Develop processes to accommodate the emergence of integrated health delivery systems and transition of patient care to non-acute settings.	Metzger, Jane B., Margret Amatayakul, Ned Simpson, "Lessons Learned from the Davies Program: The First Four Years."
c. Prepare for ICD-10-CM and ICD-10-PCS.	AHIMA Coding Policy and Strategy Committee. "Practice Brief—Preparing Your Organization for a New Coding System." *Journal of AHIMA* 69, no. 8 (1998): insert.