Boosting Efficiency in Home Health Record Systems

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by Prinny Rose Abraham, RHIT, CPHQ

The growing pains of the past decade have led to medical record backlogs and record retrieval crises for many home healthcare agencies. These problems have pushed more than one agency director into enlisting the skills of an HIM professional to evaluate the medical record systems in place and develop a more systemic approach to maintaining the agency's health information systems.

This is one consultant's approach to the evaluation and system redesign of a home care agency. The problems outlined are common to many agencies, particularly those that have not used an HIM practitioner to develop or manage their systems.

Start with the Basics

Many agencies lack what HIM practitioners may consider the most basic medical record functions: a user-friendly chart order, efficiency in filing, and organized record retrieval systems.

Simplifying your agency chart order will have a big impact on direct caregivers, case managers, and clerical staff. The home care medical record is typically housed in a cardstock folder with records attached on both sides. This type of folder is more space-efficient than a ring binder, particularly for large agencies with a high volume of patients. By eliminating or minimizing discipline or ancillary-specific tabs and filing in reverse-chronological order (most recent records on top), readers can easily review the record from a delivery and care coordination perspective. It also simplifies the filing and reconciliation process.

To create an efficient file system, first centralize the records. Many agencies have decentralized filing, where the records are separated into several shelving units for "active," "incomplete," and "discharged" records. This forces agency clerks to look in three places for a chart instead of one. Instead, keep the files in one location and place labels on the folders' tabs to display their status.

For many agencies, the next step toward efficiency is converting from an alphabetic to a numeric filing system to decrease filing errors. In home care, every document generated is a loose sheet of paper and must be filed in the medical record. The sheer volume of documents to be filed necessitates a system that minimizes errors and decreases the number of times staff must touch a document to file it in the correct record.

The final step in achieving filing efficiency is to implement a drop-filing system for loose records. Each document to be filed is placed in the front of the chart. Once a week, all of the active and incomplete charts are pulled and the documents in the front of the chart are placed in reverse chronological order and secured in the record. Any time the chart leaves the record area, it is reviewed and loose documents are secured in proper order. Pulling and filing in the chart on a weekly basis helps clerks detect inconsistencies better than when the chart is pulled daily. For example, a clerk may ask why there is only one aide note among seven nursing notes and then look to see if the aide note belongs to another patient. Drop-filing works particularly well for records maintained in the interdisciplinary chart order discussed above.

Install Coding Checks and Balances

It is important to assess the agency's current method of assigning diagnosis codes and then build quality checks into the process to answer the following questions:

- Who assigns ICD-9-CM codes in the agency? Do they have training and understand coding issues specific to home care? Are the codebooks, computerized reference files, or coding crib sheets kept up to date?
- How are updates from the fiscal intermediary (FI) distributed? Is the coder made aware of FI directives? Does the billing department consult with the coder when modifying coded data to get a claim processed?

- Does the completed HCFA 485 data entry tool accurately reflect primary and secondary diagnoses and surgical procedures, including correct onset and exacerbation dates?
- Does OASIS data or the data collection tool contradict 485 documentation?
- Do ICD-9-CM codes and descriptions printed on the 485 match data submitted to data entry?
- Will code descriptions and specificity meet agency needs for statistical reporting, data analysis, and prospective payment reimbursement?

Automate Physician Order Tracking

Implementing a system to track the signature and return of physician orders/physician certifications (HCFA form 485) is critical in home care from both a regulatory and billing compliance perspective. Home health agencies have reported that the most common reasons for denials of Medicare claims are due to a lack of timely physician orders or physician certification. Every agency must have a system in place to track timeliness and return. No service should be billed unless it is ordered, signed by the physician, and returned to the agency.

Tracking orders can be easily automated by using off-the-shelf software programs like Microsoft Excel or Access and entering the date the physician gave the order, the physician's name, and the patient's name/medical record number. To expedite the data entry process, assign the referring physician a unique code number. Consider asking your forms vendor to print a unique number or bar code on all physician orders to simplify the process.

The software program selected should have the ability to count and sort delinquent order data several different ways to proactively investigate patterns and trends. Physicians' offices find it hard to argue when a clerk can say, "We sent this order for signature three times over the last 30 days. Your practice has 22 unsigned orders more than 30 days old. How can we continue serving your patient's home care needs without putting our agency out of compliance with federal regulations or limiting our ability to bill?"

Establish Performance Measures

To assist in evaluating HIM staffing levels, particularly in large-volume agencies, the following productivity/ performance measures and monitors may be helpful.

- number of loose documents received, filed, or redistributed daily, including oldest document date
- number of assessments (OASIS and certifications) received and entered daily, including oldest assessment date
- number of physician orders received and sent daily
- number of delinquent orders remaining on the first and 15th day of the month, including oldest order date
- monthly revenue unbilled due to signed orders not found in file
- number of physicians' offices contacted weekly to retrieve delinquent orders
- number of chart requests received and filled weekly

Initially, health information personnel may resist counting and reporting workload. However, they will soon see the value in helping others understand the volume of paperwork moving through their department. It is easier for administrators to respond to volume changes stated objectively through numbers.

The federal government's crackdown on fraud and abuse has been especially intense for the home health industry. You can expect to see an even greater emphasis on medical record documentation as the home care industry prepares for prospective payment systems. As a result, home care agencies are looking to health information professionals to apply systems thinking when managing their HIM activities.

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