Completing Charts in EHRs

By Lou Ann Wiedemann, MS, RHIA, CPEHR

This issue the Journal introduces a new "Working Smart" column offering best practices for working in the e-HIM environment.

Since the advent of the HIM profession many have struggled with the chart completion process. In the paper environment, the process began with assembling mountains of paper into a logical order and sequence. From there clerical staff spent countless hours reviewing pages for signatures and missing documentation.

Many of these processes still remain in the EHR. "It really comes down to a process that is shorter, but sometimes more time-consuming," says Bonnie Irzyk, RHIT, HIM manager at VNS Home Health Services in Rhode Island.

This column outlines practice guidance for completing a record in an electronic environment.

Defining Chart Completion Policies and Procedures

The first step in the chart completion process is to review regulatory guidelines, including any state-specific, Joint Commission, or Centers for Medicare and Medicaid Services guidelines regarding record completion.

Most organizations require that each entry within a record be signed. State regulations may further outline that entities include the date and time with the signature. These requirements, and any other requirements, should be outlined in an organization's chart completion policies and procedures.

Organizations should ensure that their policies and procedures are up-to-date as processes change. Irzyk recommends keying in on specific terms such as "paper" when reviewing specific department policies and procedures. In such an instance, organizations can simply change references from "paper" to "electronic."

Policies and procedures should define when a record is complete. For most organizations, a record is complete once all applicable signatures and reports are verified to be part of the record. The organization should then define which signatures and reports the HIM department will confirm.

For example, at OU Medical Center in Oklahoma City, HIM manager Valerie Bell, RHIA, considers a record complete when the clerical staff has confirmed that it contains a "history and physical, discharge summary, applicable consultations or operative notes as well as signatures on each report and all physician orders." If one physician order is missing, the record remains incomplete until that order is signed.

This is the same policy that was in place when the record was completely comprised of paper. The only process that has changed is the process by which reports and signatures are obtained.

Irzyk also recommends that every department define its legal electronic health record. A documentation crosswalk can provide guidance on the components of the legal health record. It will also help HIM professionals address other issues, such as electronic signature, within other policies.

For example, an organization that has implemented electronic signature no longer must obtain manual signatures. Instead of reviewing and placing a manual deficiency into an HIM tracking module, EHR systems have built-in queues that recognize the author and the need for a cosignature. The order is automatically sent to the appropriate physician for counter signature. No manual review is needed.

Chart Completion Challenges

A major challenge for HIM professionals is learning an EHR system's functionality. Irzyk found that "understanding the logic of the software" was a major hurdle to overcome at VNS.

The software VNS chose allowed providers to enter clinical notes; however, it did not provide e-signature functionality for all modules. The issue was quickly recognized by working closely with providers and IT. The HIM and IT departments were able to adapt a system "task" function as a workaround. The HIM department completes the task, which sends a notification to the clinician to complete the record deficiency. Once the physician completes the deficiency, an edit list is reviewed in the HIM department to complete the record.

HIM professionals should not be afraid to ask system questions, nor should they assume that if a system has electronic data entry it automatically allows e-signatures.

In addition, the number of people entering data on the front end increases as more modules are moved to the electronic environment. If information is entered incorrectly on the front end the HIM department has additional clean-up on the back end. "It is 'garbage in, garbage out,'" Bell notes.

For example, if a nurse enters a verbal order and links it to the incorrect physician the HIM department usually finds out after discharge. The system assigns the signature to the incorrect physician, who then comes to HIM to have the order corrected.

HIM professionals must understand the functionality of the software and how physicians are assigned in these instances. "If we [HIM] don't understand, the number of incorrect deficiencies continues to increase and physicians get frustrated with a system that does not appear to work correctly," Bell says.

Another major challenge for HIM professionals is job responsibilities. Many providers feel that record completion activities are clerical functions and do not fall within their scope of services. However, these functions are no longer black and white in an electronic environment.

For example, when implementing computerized physician order entry, a key process in the paper world was the transcription of the order. Many times a ward clerk reviewed the order and then transcribed the order into the different ancillary modules (e.g., medications to the pharmacy or chest x-ray to the radiology department). As ward clerks entered the order they answered key questions such as "Is the patient required to have nothing by mouth?" prior to the test.

In the electronic world these questions are flagged for the provider entering the order to answer. Physicians may feel overwhelmed at the beginning of the electronic order implementation because they are not accustomed to answering these types of questions.

Another challenge for HIM professionals during the transition is the hybrid process that occurs while modules are being implemented. During this time period providers may be completing records electronically and manually. Clerical staff must then identify which providers are signing electronically and which are signing manually.

EHR Chart Completion Lessons

- Learn as much about the EHR system as possible
- Work closely with IT and clinicians, and keep communication open
- Test system upgrades extensively
- Understand downtime procedures
- Do not be afraid to ask questions
- Require all providers to use each implemented module
- Do not expect the EHR to fix all of the chart completion deficiencies

In a facility with a large medical staff this process can bring HIM processes to a screeching halt. "It is a huge problem that is often overlooked," Bell says. The HIM department should be aware of chart completion concerns before beginning the

transition. “Just go into the implementation being aware of back-end difficulties,” she recommends.

As HIM professionals move toward an electronic record there are several lessons to be learned. Completing health records and maintaining the integrity of the information is a fundamental HIM function that cannot be lost in the transition to an EHR.

“Just when you think you have it down, something new happens,” says Irzyk. “However, the end product is more accurate, and the documentation is better.” HIM professionals can take advantage of the EHR to streamline record completion processes and minimize duplication of effort.

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