Leaders of e-HIM: Three Grace Award Finalists Share Data Integrity, Documentation Improvement, and HIE Plans and Practices

By Julie A. Dooling, RHIT

In October 2012, AHIMA's Grace Whiting Myers Award was presented to the University of Wisconsin Hospital and Clinics in recognition of excellence in health information management (HIM). This inaugural award focused on organizations who have demonstrated effective and innovative approaches to using health information while delivering high-quality healthcare.

Award finalists included Boston Children's Hospital, Cleveland Clinic Health System, and Vanderbilt University Medical Center. These award-winning organizations recently shared some insights for the year ahead and discussed how they have become leaders in the emerging electronic HIM field.

Focusing on Data Integrity

For the health information professionals in key administrative roles at these organizations, documentation improvement and data integrity is a major focus area that enhances day-to-day operations and improves quality.

Mary Radley, RHIA, director of HIM at Boston Children's Hospital, said her department has recently established an area focused exclusively on data integrity. "The staff in this area investigate and address data integrity issues in our electronic health record and also perform quality audits for the scanning and indexing process," she says.

The staff dedicated to this initiative take calls from clinicians and help them correct errors they made when creating a note. The data integrity staff also help to resolve a duplicate or erroneous entry. Internal requests may involve a staff member who notices a certain document or note posted to the incorrect encounter or incorrect patient. On occasion they receive requests from a patient or family member who report summary list entries that need to be corrected.

Building Strategic Documentation Initiatives

The Cleveland Clinic is expanding the function of the Documentation Extraction Reporting and Transformation (DERT) Committee to include a strategic design and build an enterprise documentation and data integrity solution that results in improved patient care and quality outcomes.

In addition, Cleveland Clinic's HIM department is collaborating with key stakeholders that will drive the implementation of several documentation integrity projects. "Our goal is to ensure that provider documentation is accurate and complete at the point of care, which is essential in the coordination of patient care," says Kathy Hartman, RN, MSN, CNS, senior director of HIM and revenue cycle management at the Cleveland Clinic. "Our vision is centered on quality patient care and we will leverage the benefits of ICD-10-CM/PCS, especially as it relates to quality metrics and granular patient data."

Hartman's team is also working on additional documentation and quality initiatives such as the use of EHR templates and various chart etiquette programs, serving as active participants on EHR subcommittees to help design EHR navigation tools, maintaining and preserving their very successful accomplishment of zero delinquent medical records, and using the accurate and reliable data to focus on predictive modeling.

Reporting Key for Record Improvements

The Enterprise Data Integrity Team at Vanderbilt University Medical Center is one focus area for Mary Reeves, RHIA, administrative director of medical information services. The Legal Medical Record Team responds to provider and user electronic requests for corrections and retractions in the EHR. They provide coverage 24 hours a day, seven days a week to complete corrections within 24 hours of the initial request.

Reeves's team monitors data integrity by reporting EHR documentation content standards and errors and discrepancies in the master patient index (MPI). The findings are aggregated and reported to the EHR Data Governance Executive Committee.

Content standards are gathered real-time during the patient's stay. The clinician is electronically notified if documents like history and physicals, consultations, and operative notes are not completed and signed within 24 hours of the service. These reports become delinquent immediately if not completed within the timeline. Providers with repeated delinquent documentation within a six-month interval are subject to sanctions.

MPI statistics include the percentage of duplicate medical record numbers created, an aggregate of duplicate creation and a listing of responsible departments or registration areas and the data discrepancies causing duplicates.

In 2013, Boston Children's will also focus on proactively identifying potential data integrity issues in the EHR so that their resolution of errors is more preemptive.

"We have created a list of potential errors we want to identify through database queries so corrections can be made closer to the time the entry was created," Radley says. "These queries will assist in verifying the accuracy of the documentation." Query criteria may consist of:

- Unsigned notes or orders that are still unsigned after patient discharge
- Documentation on a future encounter
- Documentation on a past encounter
- Inaccurate and inconsistent data input, such as dates with inconsistent formats, medication and diagnosis misspellings, and incomplete data

"It is important for patient care to develop ways to identify potential data integrity issues using electronic data," Radley says. "EHR entries can populate many different locations in the record, and errors can carry forward in places that one would not expect. Identifying and resolving those errors is important to ensure the integrity of the patient record and provide a record of care that providers can depend on as a source of truth."

Patient Portals Highly Recommended

Rates of sharing information beyond institution walls and helping patients to access vital health information is once again expected to increase in 2013. All three award finalists have patient portals that help to facilitate communication between healthcare providers and their patient. Hartman says the Cleveland Clinic's patient portal has been an "effective practice for consumers who have the ability to sign-up online, receive patient reminders, and receive informational brochures." Enhancements to the patient portal are planned at Boston Children's in the near future.

Vanderbilt has had a patient portal for 10 years serving a total of 250,000 users. Currently, 3,500 new users utilize the portal every month. During peak days more than 5,000 patients access the patient portal, Reeves says. Two HIM-credentialed coordinators interact daily with patients using the portal and educate them on the different ways they can access their protected health information. Examples of the support these coordinators provide include:

- One-on-one patient education in patient care areas
- Assistance with applications
- Responding to telephone requests
- Helping individuals in other scenarios gain access to records, such as parents or a designated legal representative for an elderly parent

The coordinators also advise patients how to obtain a complete copy of their medical record at walk-in Vanderbilt locations, where patients may request up to 50 pages at no charge.

Facilities Adopted Advanced HIE Practices

Boston Children's Hospital was an early adopter of the Massachusetts Health Information Exchange (HIE) that launched October 2011. This new exchange allows patient health information to be transmitted securely between healthcare providers and organizations for better care coordination and increased patient safety, with the goal of lowering healthcare costs. In addition, Boston Children's created a direct link for sharing between two non-affiliated organizations through a "magic button" that has been in use for approximately one year. This button allows providers at Atrius Health to access patient information from Boston Children's EHR when they are accessing records belonging to a patient using both providers. There are plans to complete reciprocal integration by 2013 that would implement the "magic button" in both hospitals' EHRs to enable sharing of information in both directions.

Cleveland Clinic is participating in sharing information through an electronic exchange that links other organizations that have implemented an Epic EHR in their facilities. The facility is also exploring options for non-Epic health systems to connect to their system using the "Care Elsewhere" functionality within their EHR.

In addition, they are considering building a gateway to share Social Security Administration disability requests and using the Centers for Medicare and Medicaid Services' Electronic Submission of Medical Documentation model for further electronic release of information.

Kathy Hartman says that information must be electronically shared today, not just in the future. "As consumers request more information regarding their care and healthcare highlights the quality of care given, the importance of sharing information through an HIE will only be emphasized," Hartman says.

These award-winning organizations showcase one common goal through their plans and practices-capturing and maintaining accurate and complete patient information through areas such as documentation improvement, data integrity, and health information exchange-all areas of healthcare that are focused on quality patient care and are best handled by well-trained HIM professionals.

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