Mastering the Information Management Standards

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by Jean S. Clark, RHIA

For HIM professionals working at organizations surveyed by the Joint Commission on Accreditation of Healthcare Organizations, the information management standards are critical. Here's an overview of the key points and top issues surveyors look for.

Whether you work in acute, long term, home, or behavioral healthcare, chances are you're familiar with the Joint Commission's information management (IM) standards. These guidelines have been incorporated into accreditation manuals for some time.

In 1998, all scoring caps were removed from the standards, so organizations are expected to understand and be in compliance with the standards. Because surveys continue to result in Type 1 recommendations (those that address insufficient or unsatisfactory compliance) related to selected standards in the IM chapter, it's apparent that meeting the standards isn't always easy. Are you up to date on the key points of each standard? Do you know what top issues surveyors are looking for? This article offers a brief overview.

HIM professionals know that the goals of an organization's IM function are to obtain, manage, and use information to improve patient outcomes and individual and hospital performance. Processes must be designed well to facilitate the definition, capture, and interpretation of data—with the ultimate goal of transforming it into usable information for decision making, research, performance improvement, and patient education. The standards identify four types of information:

- patient-specific
- aggregate
- expert knowledge-based
- comparative

Information Management Standard 1—Assessing, Planning, Designing

IM.1 requires the organization to plan the management of information based on the needs of users, both internal and external. This has been a troublesome standard because organizations have focused on computer applications, which has resulted only in an information technology plan. The intent of the standard is to assess the information needs of the organization as they relate to the above four types of information and then to develop strategies and plans based on the findings. The processes of assessment and planning should be multidisciplinary and ongoing.

Remember, the standard does not require an information management plan, although many organizations have one. It addresses not only computers but the overall management and use of information. Surveyors are looking for evidence of a periodic assessment and how the results of the assessments are planned for and implemented.

Information Management Standard 2—Security and Confidentiality

IM.2 focuses on security and confidentiality of data and information. Again, this applies to all four types of information. Policies and procedures should address the written, computerized, verbal, and visible use of data and information. Noncompliance with this standard can result in multiple Type I recommendations related to other standards, such as Patient Rights and Organizational Ethics. In the last year, there has been a particular focus on confidentiality.

Surveyors will be observing the location of "white" boards, the confidentiality of registration areas, and access to medical records as well as computer safeguards, to name a few examples. Don't forget about areas that are closed in off hours,

especially physician offices that the organization owns.

Information Management Standard 3—Standardization, Ongoing Record Review

Although this standard requires that uniform data definitions and capture methods are to be used, the real focus of the standard is directed at the ongoing review of medical records. Surveyors are looking closely at the process and results of ongoing review—and 4.7 percent of hospitals surveyed from January to June 1999 received scores of 3, 4, or 5—scores that will result in a Type 1 recommendation—for IM.3.2.1.

The standard requires that:

- medical records are reviewed on an ongoing basis for the completeness and timeliness of information
- action is taken to improve the quality and timeliness of documentation that affects patient care
- reviews are based on a sample of records, which represents the practitioners providing care and the care provided. However, it is not necessary to review a record for every physician who has privileges on the organization's medical staff

The intent requires that the medical records review addresses the presence, timeliness, legibility, and authentication of the 19 items listed in the intent, as appropriate to the organization's needs. At minimum, the medical and nursing staff and other relevant clinical professionals should conduct the review process. The reviews should focus on the open record. Findings from reviews and medical record completion statistics must be reported at least quarterly. A 12-months' track record is expected, as well as completion of the quarterly medical record review summary form.

Compliance with this standard is not as difficult as it seems. It might be helpful to take a performance improvement approach to ongoing record review. Involve the caregivers who write in the records in record review and problem resolution. Although an organization can develop its own review criteria, the Joint Commission provides the most comprehensive criteria set in its closed medical record review tool, which will be used in 2000 for both open and closed record review (available on the Joint Commission's Web site, www.jcaho. org). Use this tool to take a baseline review at least twice a year, then focus on resolving the identified problems. As much as possible, discontinue the closed record review process and focus reviews at the point of care.

Take a look at legibility. Organizations are receiving Type 1 scores here and in the related standard under MS.8.2.3, the medical staff chapter of the accreditation manual that requires medical staff to participate in the improvement of patient care processes, including completion of medical records.

IM standards 4 (education of staff as it relates to information management), 5 (timely and accurate transmission of data and information), and 6 (integration and interpretation of data and information) generally have not been troublesome standards. Surveyors will focus on findings from staff interviews and observations to score these standards. In this case, it is important for all staff, including physicians, to understand the standards, along with the organization's related policies and procedures.

Information Management Standard 7—Patient-specific Data and Information

These medical record standards are all too familiar, but they continue to wreak havoc at the time of surveys. The following standards have received Type 1 recommendations in January to June 1999:

- IM.7.3.2—Operative reports dictated or written immediately after surgery (4.5 percent)
- IM.7.3.2.2—When the operative note is not placed in the medical record immediately after surgery, an operative progress note is entered (7.5 percent)
- IM.7.4.1—For ambulatory care patients, the summary list is initiated by the third visit and maintained thereafter (2.4 percent)

- IM.7.6—Medical record data is managed in a timely manner (7.1 percent)
- IM.7.7—Verbal orders are accepted and transcribed by qualified personnel (19.4 percent)
- IM.7.8—Every entry is dated, author identified, and authenticated when necessary (5.3 percent)

Surveyors will be looking for a postoperative progress note to be written in the medical record immediately after surgery for inpatients and outpatients. An easy way to meet this standard is to have a fill-in-the-blank form for physicians to use rather than depending on a handwritten progress note. It is also important to have a policy that requires charting of all dictated operative reports within a reasonable time after surgery—12 hours is a good benchmark—and signed by the physician. Surveyors will be looking for signatures on operative reports, because standard IM.7.3.2.1 requires immediate authentication of the completed operative report.

Verbal orders continue to be a challenge for almost all organizations. The standard does not require authentication of verbal orders; however, surveyors will score organizations according to state and hospital policies. Remember, Joint Commission standard IM.7.8 only requires history and physical reports, operative reports, consultations, and discharge summaries to be authenticated (signed). Any other authentication requirements will be surveyed according to state and organization policies.

Questions have arisen as to whether dictated history and physical reports need to be authenticated within 24 hours in order to be complete. The Joint Commission recently published a clarification that indicates that a history and physical must be performed and documented within 24 hours, but authentication is based on organizational policy. This is very good news, because in many cases the history and physical is not signed until after discharge as part of the delinquent process. Remember, if this is an organization's policy, the history and physical must be signed within 30 days of discharge.

It is important to remember that other standards, particularly in the patient-focused functions (assessment of patients, care of patients, education, and continuum of care chapters) are scored based on documentation in the medical record by other clinical caregivers such as nurses, physical therapists, and respiratory therapists. It is important to get all of these professionals involved in an ongoing record review process and focus the process at the point of care.

Surveyors will be looking at open records more than ever before. The focus will be on timely and adequate documentation, not just if a report is filed in the record. A good ongoing record review process and adherence to organizational policies will go a long way in ensuring good survey results as well as preparedness for a random survey.

IM Standards 8, 9, and 10 have not resulted in major issues at the time of surveys. However, as mentioned above, it is important that organizations understand the standards and their intents and that staff can articulate this to the surveyors. It is important to conduct a periodic needs assessment for knowledge-based information under IM.9. It is also helpful to create a list of external databases—ORYX, for example—that the organization uses for the documents review session.

Although the closed medical record review was still conducted in 1999, the focus will probably change to a more open record review in 2000. Organizations will have less opportunity to preselect records at the time of survey. This is all the more reason to assure that medical records are documented well at the point of care.

The IM chapter belongs to everyone in the organization. It is the basis for good patient care, performance improvement, and good decision making. Compliance with the standards is everyone's responsibility.

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