Personal Check: Patients the New Ally in Data Integrity Management

By Lisa A. Eramo

When Deborah Kohn recently logged onto her healthcare provider's patient portal to view her X-ray reports, she immediately knew something wasn't quite right. She'd undergone one X-ray of her left hand and another of her right hand. The problem?

Both X-ray reports were identical.

The report of her left hand referred to her right fingers, and all other verbiage was the same. She immediately contacted her provider to correct the error-which she suspected was due to a physician simply copying and pasting information from one report into the other.

"I'm always going back to my provider organization and saying, 'Look at these mistakes in my record,'" says Kohn, MPH, RHIA, FACHE, CPHIMS, CIP, principal of Dak Systems Consulting based in San Mateo, CA. "Until you can make my medical record as accurate as my bank statement, you will continue to see me."

Experts say data integrity is an ongoing challenge at most facilities, primarily because multiple providers enter information into what has become an increasingly dynamic health record. The good news is that HIM professionals may have a new ally who can help tackle this problem-patients.

Meaningful Use Increasing Portal Adoption

Thanks to an increasing adoption of patient portals, patients now have greater access to their health information than they've ever had before. This enables patients to not only view their data but also question and validate it, all of which is beneficial in terms of improving the accuracy of information, says Serdar Akin, vice president of Intuit Health, based in Mountain View, CA.

Intuit Health has estimated that only 20-25 percent of providers have adopted patient portal technology to date, Akin says. However, the federal government's "meaningful use" EHR Incentive Program may be the catalyst that drastically increases that number since the federal program requires patients have electronic and timely access to health information. EHR adoption is expected to reach 80 percent in the next few years, and it's reasonable to expect that the vast majority of providers with EHRs will offer patient portals, Akin adds.

Stage 1 of the Centers for Medicare and Medicaid Services' "meaningful use" EHR Incentive Program required providers to give patients an electronic copy of their health information, including diagnostic test results, problem lists, medication lists, and medication allergies, within three business days of an encounter. However, stage 2 of the program requires providers to give patients the ability to view online and download their health information, as well as transmit it to a third party, within four business days for physicians and 36 hours after discharge for hospitals. Patients must also be able to use secure electronic messaging to communicate with their providers about relevant health information. Stage 3, as it's currently proposed, would require providers to give patients the ability to request an amendment to their record online-such as offer corrections, additions, or updates to the record-through a portal.

Providers aren't technically required to comply with meaningful use, yet. But they *are* required to comply with HIPAA, which specifies that they must be able to provide patients with the ability to request amendments to their records. As providers continue to implement EHRs, patients may expect-and even demand-the ability to view and amend that information electronically via a portal, Akin says. "[Data integrity] is part of the portal value proposition, among other benefits," Akin says. "Portals, when integrated with the EHR, give patients access to their own health data. Patients will partner with their health

providers to validate their own health information." Data integrity is an indirect benefit of this growing patient engagement, he adds.

"I think the real benefit of meaningful use is having the patient as part of the equation," says Elizabeth W. Woodcock, MBA, FACMPE, CPC, consultant at Woodcock & Associates in Atlanta, GA.

Patients have a stake in ensuring data integrity. Many healthcare experts have said that accurate health information leads to better continuity of care, more accurate care, and correct billing. With a portal, patients can also easily access personalized information to make treatment decisions, improve their health, and prepare for appointments. HIM professionals also benefit from more direct patient involvement with their health information. For example, some portals allow patients to fill out registration forms online. Not only does this save time, but it also prevents illegible handwriting that can lead to data integrity problems that propagate throughout the entire record, Woodcock says.

Requiring patients to enter information through a keyboard or to select discrete information from a checklist also prevents registration staff from having to re-key information into the record and verify that it's accurate. In addition, providers can customize these forms by sex, age, chronic disease, and other factors, all of which can enhance more meaningful data capture, says Woodcock.

Patients Paying Attention to Data Accuracy

HIM professionals have seen firsthand how portals improve data accuracy. Anne Dixon, RHIA, medical information services manager at Vanderbilt University Medical Center in Nashville, TN, says data integrity has improved significantly since the health system implemented its patient portal, MyHealthAtVanderbilt, in 2004. "It's not just our eyes doing the QA on the record. It's the patients' eyes also doing the QA. The more eyes you have on the record, the more errors you catch," she says.

Approximately 213,500 patients currently use the MyHealthAtVanderbilt portal. After patients first present in person at the hospital and provide a photo ID, they have portal access to most lab results, radiology reports, a chronological view of vital signs, a list of immunizations, and a summary of medications, allergies, and health problems.

Patients also have access to a self-management tool where they can input data, such as blood pressure readings. To ensure data integrity, a nurse reviews the patient-provided information and approves it for downloading into the EHR. If a patient inputs a high or low reading, a pop-up will prompt the patient to call the nurse.

Penny Sherek, RHIA, CDIP, health data coordinator at Vanderbilt, says now that patients have access to their health information they are inspired to ensure accuracy. This is a big advancement from just a few years ago when patients rarely considered the accuracy of their health information. "I think that the portal has empowered patients. They want to make sure that everything is correct so they get the best healthcare possible," she adds.

It is now common for patients to request amendments for medication changes, employment changes, or typographical errors related to weight or blood pressure, Sherek says.

Although patients can message physicians directly through the portal regarding amendments, physicians forward those requests to the HIM department so staff members can follow up via a paper process, Dixon says. The request-as well as the provider's response to the request-is then scanned into the EHR. The reason for the paper process is purely technical.

"Our portal does not currently support patient-completed forms. That is planned for a future release and after that we would consider having the amendment forms filled out through the portal," Dixon says. Pre-appointment questionnaires, family history, and other forms will also eventually be filled out on the portal.

HIM Ensures a Smooth Portal Process

Offering a portal allows patients the ability to constantly monitor their information and often draws in individuals who might not have ever even requested a copy of their information otherwise, says Teresa Bunsen, RHIA, chief privacy officer and senior director of health information record services at NorthShore University HealthSystem, based in Chicago, IL.

At NorthShore, approximately 195,000 patients actively use the health system's portal, NorthShoreConnect, to access lab results, radiology reports, and summary of care documents for emergency room visits, inpatient admissions, and office visits. The health system implemented the portal in 2004. "We have the philosophy that the better connected we are with patients, the better and more integrated care we can provide," Bunsen says.

NorthShore launched its portal with a focus on patient collaboration and data accuracy. "We encourage [patients] on every screen to let us know if there are any inaccuracies. We want information to be correct," Bunsen says.

Patients receive e-mail notifications when new information has been added to their portal. The e-mail includes a link that permits secure access into the portal where information can be viewed. When patients see data that appear to be inaccurate or that require clarification, they are able to click on a section of the portal named "medical record corrections." This section includes a hyperlink where patients can send amendment requests directly to the HIM department. When the message is sent, it includes a link to the patient's EHR chart so staff members can easily review the request and relevant documentation.

This ability to request amendments online through the patient portal isn't currently a requirement to meet meaningful use criteria. However, Bunsen says it does significantly reduce processing time. "The investigation process on our end once we get the request is pretty much the same, but the back and forth communication with patients through the portal is so much faster," she says.

As with any request for an amendment, HIM staff members review the source document and then contact the provider who originally documented the information in question to determine whether the amendment is appropriate. For example, HIM staff would contact the patient's primary care provider to validate that a patient is no longer taking a particular medication. With most portals, this communication with providers takes place electronically using a function within the EHR similar to e-mail. Doing so gives providers a direct link into the patient's electronic record during the discussion, explains Marina Braun, regulatory manager at NorthShore.

Providers must either accept or deny the request within 60 days from the date of receipt of the request, according to HIPAA rules. At NorthShore, once the request is confirmed or denied, patients receive a response with the outcome using the same method of communication with which the request was originally sent. For example, if the request was sent via the portal, patients receive a response back through the portal. If the request was sent via paper, they'll receive a letter in the mail. All correspondences between the patient and provider are part of NorthShore's legal health record, per industry best practice standards. Internal communications between staff members are not included.

In addition to allowing patients to make requests for amendments, HIPAA also requires providers to maintain any requests for amendments and other correspondence between patients and their physicians for six years, Bunsen says. Therefore, HIM professionals should ensure any new EHR system implemented has this capability.

Addressing Increasing Amendment Challenges

Although patient engagement is a primary goal of portal implementation, one challenge is that the number of amendment requests increases significantly once patients have easy access to their information. Experts agree that these requests will likely continue to increase once patients have access to progress notes and other information in the record.

At NorthShore, the overall number of amendments, including those requested via paper or phone, has quadrupled in the last few months, adding pressure to HIM staff members' workloads. Currently 80-85 percent of requests are sent through the patient portal. The bulk of these relate to medication changes or updates to past medical history, Braun says.

Dixon has seen a similar increase in requests for amendments at Vanderbilt. Requests initially numbered 30-40 per year in the early days of their portal. Most of these requests were attributed to increased patient awareness due to HIPAA, which became effective one year before the patient portal went live in 2004. Today Vanderbilt receives hundreds of amendment requests per year. Sifting through and coordinating all of these requests is no easy task.

Bunsen says that 50 percent of the amendments at NorthShore are ultimately denied. These amendments typically pertain to emergency room documentation regarding the specifics of an accident. "Someone taking the notes might paraphrase [the circumstances of the accident] accordingly into the chart, and then the patient gets access to the information and they don't like the way it reads," she says.

Many amendments also pertain to the NorthShore portal's health maintenance section, which provides reminders for patients to undergo certain preventive tests, such as screening colonoscopies or mammograms, Bunsen says. "If patients choose to have these tests outside of NorthShore, the [EHR] doesn't know it, and the [EHR] doesn't get updated," she says.

Staff members at Vanderbilt generally distinguish between corrections (i.e., smoker vs. non-smoker) and more subjective changes (i.e., disagreeing with a physician's diagnostic statement of bipolar disorder), Dixon says. Amendments that aren't typically approved are those that involve a diagnosis a physician has made based on clear clinical criteria, including lab and X-ray findings, as well as professional observation.

Generally speaking, patients are becoming more keen observers of the specific language that physicians use to describe them, and thus subjective changes seem to be in high demand, Kohn says. For example, some patients may request an amendment to delete the term "obese" from their record because they are offended by it. "We need to be proactive about these unintended consequences that we're starting to see with patients," Kohn says. "It has become an administrative burden on the HIM department. You don't want the entire record filled with amendments."

This is why patient education is such an important part of the amendment process, Bunsen says. Patients don't always understand that the original note, for example, will continue to exist in the record along with an appended note that includes the corrected information. "Patients want the information removed. To them, an amendment means the information is wrong, and it needs to be removed," she says. "That would be illegal for us to do. We have to spend a lot of time and finesse getting them to understand this."

Sherek says she can speak on the phone with dozens of patients per month explaining why certain requests are denied. "It can be very challenging, but we need to keep our perspective while also listening to the patient and being compassionate," she says. "Sometimes I think patients just want to be heard."

HIM Must Build Patient Alliances

Although patients certainly have the potential to become HIM's greatest ally in ensuring data integrity, this symbiotic relationship will only occur if patients initially sign up for the portal.

Patient engagement begins as early as the moment the physician interacts with the patient in the exam room, says Woodcock. This includes discussing test results or showing exam findings or images on the computer for ease of understanding. "If you introduce the information early on in the process, I think that really engages patients and furthers the goal of accuracy," she says.

It is paramount that providers raise awareness on the importance of patient involvement with their health information, Kohn says. "Patients don't know they can ask for copies of their records, let alone amend them," she says. "They may think that the doctor is doing everything right and that there are no errors in their records."

HIM professionals should help educate patients by putting up signs around the organization about HIPAA, their patient portal, and how patients can access their records, Kohn says. Departments should consider designating a liaison that can assist patients with questions about the portal and make amendments to their records. This doesn't necessarily need to be a newly-hired individual. It could be a former file clerk, for example, with excellent and sensitive communication skills, she adds.

Others have taken an even more proactive approach to patient engagement. One practice Woodcock recently worked with had a nearly 100 percent participation rate in its portal because it required patients to log on to the portal to complete pre-visit paperwork before they could schedule an appointment.

NorthShore plans to more aggressively focus its efforts on patient engagement throughout the summer, Bunsen says. For example, physicians will provide after-visit summaries to patients that include an explanation of how to log on to the portal at home. NorthShore is also considering patient portal kiosks in the emergency room and physician office waiting areas.

"Some of our discussions will be about how we will engage them when they come in for the visit," Bunsen says.

Vanderbilt has set its sights on revamping the patient portal to accommodate users of mobile technology, Dixon says. "We feel that we will reach a much greater patient population through smartphones than we will through laptops," she says. "We won't

have an app, but the screen will resize depending on whether you're using a smartphone or a laptop, and you'll be able to see the same information."

The Future of Data Integrity

Experts say challenges will persist in achieving data accuracy and patient engagement until true EHR interoperability is achieved.

"As we try and expand into meaningful use stage 2, we know we're going to run into more patients whose primary care doctors are not a part of our medical group and therefore not participating in the patient portal," Bunsen says. NorthShore's portal vendor plans to provide a "lite" option for these patients so they can view their after-visit summary but not have the ability to message physicians directly. This should limit the volume of amendments, she adds.

But as EHR interoperability takes center stage in healthcare, it's likely that patients will eventually have access to their entire longitudinal health record through a portal, Akin says.

"Patients will be able to see data coming from different doctors regardless of what EHR their physician uses," he adds. "Ultimately, this is one of the goals of meaningful use-to put patients in control of their healthcare and to help them partner with providers to ensure data integrity."

Lisa A. Eramo (leramo@hotmail.com) is a freelance writer and editor based in Cranston, RI, who specializes in healthcare regulatory topics, health information management, and medical coding.

Article citation:
Eramo, Lisa A. "Personal Check: Patients the New Ally in Data Integrity Management" *Journal of AHIMA* 84, no.5 (May 2013): 26-29.