Reengineering the Documentation Process

by Darice Grzybowski, RRA, and Leslie Ann Fox, MA, RRA

Project Rationale and History

We dream of a world where all medical record forms are complete and legible, neatly and proportionately designed, easily converted into electronic format, and efficient for those who document in them; contain clear identification data; and meet all legal, accreditation, and reimbursement standards. Instead, the real world of medical records is one where carbonless forms and foldouts are abundant, and a single data item may be recorded by three or four different practitioners in six or seven locations within a single patient encounter. Yet, despite this glut of entries, staff often cannot locate a critical piece of information for continuity of care or data abstraction.

HIM practitioners who expect to automate medical record documentation completely must first grapple with the challenge of getting the paper record under control. This article demonstrates some short-term strategies that HIM practitioners can use in addressing this challenge while simultaneously paving the way for the paperless record. Just as those individuals who learned how to perform manual diagnosis-related group (DRG) grouping via paper flowcharts are now experts in data classification and automated groupers, those who can master work flow analysis, data display, and forms design (or redesign) will become experts in the realm of electronic records.

Hinsdale Hospital, a 400-plus bed community hospital providing inpatient and ambulatory general medical and surgical services, and obstetrical, behavioral, and rehabilitation services, decided several years ago to pursue the elusive dream of the perfect documentation system. The impetus for change came from many sources. Staff members expressed a high degree of frustration with the existing medical record documentation process. Clinicians and the HIM staff were overwhelmed by the demands of patient-centered care and its need for integrated documentation and the concurrent installation of a computerized point-of-care nursing notes system. Documentation became increasingly fragmented and redundant. A plan to evaluate and implement an optical storage and work flow system was already in the works. Yet everyone agreed that more had to be done to make patient records and the documentation process more functional. Finally the advent of the Joint Commission's 1994 Information Management and Patient Care chapter standards, which encouraged multidisciplinary nonduplicative recording of health information, provided the final incentive to launch a project to reengineer the documentation process. Hinsdale Hospital, in partnership with Care Communications, developed a plan to reduce medical record documentation time without compromising patient care or documentation standards.

The project goals were to:

1. Obtain a complete inventory of all forms (printed, electronic, computer-based, PC-generated, externally purchased) used in all settings-inpatient, emergency, clinics, etc.
2. Determine a universal chart order for active and discharged patients and to create a set of clearly labeled/indexed dividers that would be kept with the paper record both prior to and after discharge
3. Redesign all forms to be user friendly and electronically compatible (same format, title, bar coding, numbering system, demographic data capture, etc.)
4. Streamline the caregivers' documenting process by redesigning forms to capture only those data elements that were required to support patient care, comply with regulatory and accreditation agencies, support risk prevention, or optimize reimbursement

To accomplish the first two goals, a task force consisting of nursing, physician, and health information management staff was established. Forms inventory was completed after a year of gathering samples of each form, identifying responsible parties, determining where the forms were generated and stored and whether they were electronically compatible, and applying inventory numbers to every form. The total inventory included approximately 800 different forms-300 were specific orders and order sets. Procedures were rewritten or revised to implement the universal order change process including: chart pack

(preassembled record) dissemination, assembly and analysis (clinical pertinence review), thinning of records, forms approval, loose report filing (concurrent), and other miscellaneous processes.

Goals three and four focused on individual departments. For each department, a work team was established consisting of the HIM director, a department representative (usually a manager), several team members representing caregivers, and a Care Communications consultant. The first departments to participate in the project were Rehabilitation Medicine, Behavioral Medicine, and the Emergency/Ambulatory Clinic. Each team worked for approximately 12 weeks to understand the documentation process, analyze the documentation needs and requirements, and assess the opportunities for change. Each had the same objective-forms reduction or redesign, enhanced productivity of caregivers, and preparation for the eventual implementation of electronic records.

Methodology

The HIM department assumed the role of sponsor for the process and applied the following six-step methodology:

1. Define the scope of the project and team goals
2. Identify documentation concerns of caregivers and users
3. Define the minimum required data elements for meeting patient care and other information needs
4. Describe current documentation practices
5. Identify opportunities to improve the quality and efficiency of documentation practices and medical record forms
6. Develop an action plan to change the documentation process

The HIM consultant met with each reengineering project team to define the scope of the project and to establish goals specific to each team's department. One key to success is getting caregivers involved and committed to change from the beginning. It was emphasized that the purpose of the project was to improve work flow, eliminate unnecessary paperwork, and assure access to patient care data when it was needed.

At the initial meeting, the consultants invited the teams to describe their greatest frustrations and concerns regarding medical records, to give an overview of the patient care process in their area, and to explain how the documentation process impacted their daily routines. The consultants heard from team members in one department that their patient care process had several different professionals performing initial patient assessments, resulting in redundant documentation of several categories of assessment data. Another group discussed its concern about the negative impact that a new nursing point-of-care system had on access to patient information, information flow, and the usability of the resulting computer-generated documents that were placed in the records. Others talked about records being fragmented when they were closed out for administrative reasons as the patient progressed from level to level across the continuum of care. Issues raised by the clinicians related to the need for the record to better support the patient care process.

Based on interviews with representative caregivers in a department, the consultants developed a table of the data elements that were currently documented. They then collected and reviewed the documentation standards of the appropriate regulatory and voluntary accrediting agencies. They also ascertained documentation requirements as they related to risk management and reimbursement issues specific to the hospital.

The final version of each table of data elements clearly illustrated to team members the data elements that were required for documenting patient care in their departments, who required them, and why. The HIM director viewed the development of the data element table as the heart of the project. Though tedious and time-consuming to create, it was well worth the effort because it provided objective, factual information to motivate and justify change. Although there was some concern that accrediting and regulatory requirements can change from year to year, the data element tables could be easily maintained on an annual basis.

The next step entailed reviewing a representative sample of patient records from each department. The consultants looked at how data elements were recorded, who recorded them, at what point in the process each element was recorded, and where each was recorded. They checked for the absence of required data elements and also made observations about the usability of the documentation as recoded, the format of the forms, completeness of required data elements, and other regulatory compliance issues as appropriate. The consultants constructed a table that showed how, when, where, and by whom each

required data element was documented, enabling the team to readily see the documentation redundancies or gaps. The data from this activity were also used to meet clinical pertinence review requirements for the departments being audited.

Finally, recommendations and suggestions were made for combining or eliminating forms, formatting issues, and policy and procedure changes. After receiving and reviewing the consultants' reports, the teams met with the HIM director to develop plans for action. Enthusiasm for and commitment to implementing the plans was high in all three departments because staff believed that their core issues were being addressed.

Results

The results of the first three medical record documentation reengineering projects have met or exceeded the objectives identified by the HIM department and the participating departments. The highlights are as follows:

- Eliminated approximately 20 forms
- Eliminated approximately one full-time equivalent (FTE) due to reduced documentation
- Standardized formats and eliminated redundancies (In one area 10 consent forms were consolidated into one form.)
- Integrated multidisciplinary documentation into continuous documents across different levels of care
- Successfully completed rehabilitation accrediting agency survey (CARF) that had previous contingencies
- Eliminated 100 percent Medicare audit due to improved documentation in outpatient rehabilitation
- Streamlined a registration process for outpatients that had previously required two visits to the facility
- Generated extra storage space by redesigning a record retrieval portion of clinic readmission charts
- Educated physician, nursing, and ancillary staff in current documentation standards
- Successfully piloted an optical imaging project

Conclusion

The hospital is currently in the process of completing the installation of a universal chart order. Documentation streamlining and forms reduction is still in progress because several major inpatient services are waiting for medical record reengineering (medical and surgical, obstetrics, pediatrics, and intensive services). The hospital's successful efforts have resulted in a list of departments waiting to participate in the streamlining project.

Staff members learned important lessons during this project, such as the fact that painstaking analysis of the existing documentation systems, including all processes, forms, procedures, and requirements must precede a paperless record system. Changes made as result of such efforts must address short-term issues of importance to caregivers as well as the long-term goal of moving toward a completely electronic environment. Those who develop and implement electronic records must immerse themselves in the day-to-day work of clinicians and other users of the record. It is essential to understand the treatment environment and the patient care process. Knowledge of medical record information, its unique properties, the demands it must meet, and the many masters it must serve is one of the critical contributions that HIM professionals make to the advancement of medical knowledge, treatment, and delivery of care.

Darice Grzybowski *is director of HIM at Hinsdale Hospital, Hinsdale, IL.* ***Leslie Ann Fox*** *is president of Care Communications, Inc., Chicago, IL.*

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