Reinventing HIM as Enterprise Content Management

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The University of Maryland Baltimore Washington Medical Center (UM BWMC) installed a new electronic health record (EHR) approximately three and a half years ago. As a result, significant challenges were experienced throughout the organization, but especially in the health information management (HIM) department. The department was rocketed from an almost purely paper-based system to an EHR—without a complete understanding of the new skill sets required to manage an EHR. The HIM department staff was also unaware of the complete process transformation that would need to take place. As a result, a multidisciplinary team tasked itself with determining how it would need to reinvent HIM to not only survive, but thrive in a post-EHR world. Part of that reinvention would center on evolving HIM into enterprise content management.

Today, many HIM departments and education models need to play catch up with the rapidly evolving landscape of the EHR. This article will summarize UM BWMC's journey, challenges, and successes, as well as the work that remains to be done as part of their own reinvention through the EHR.

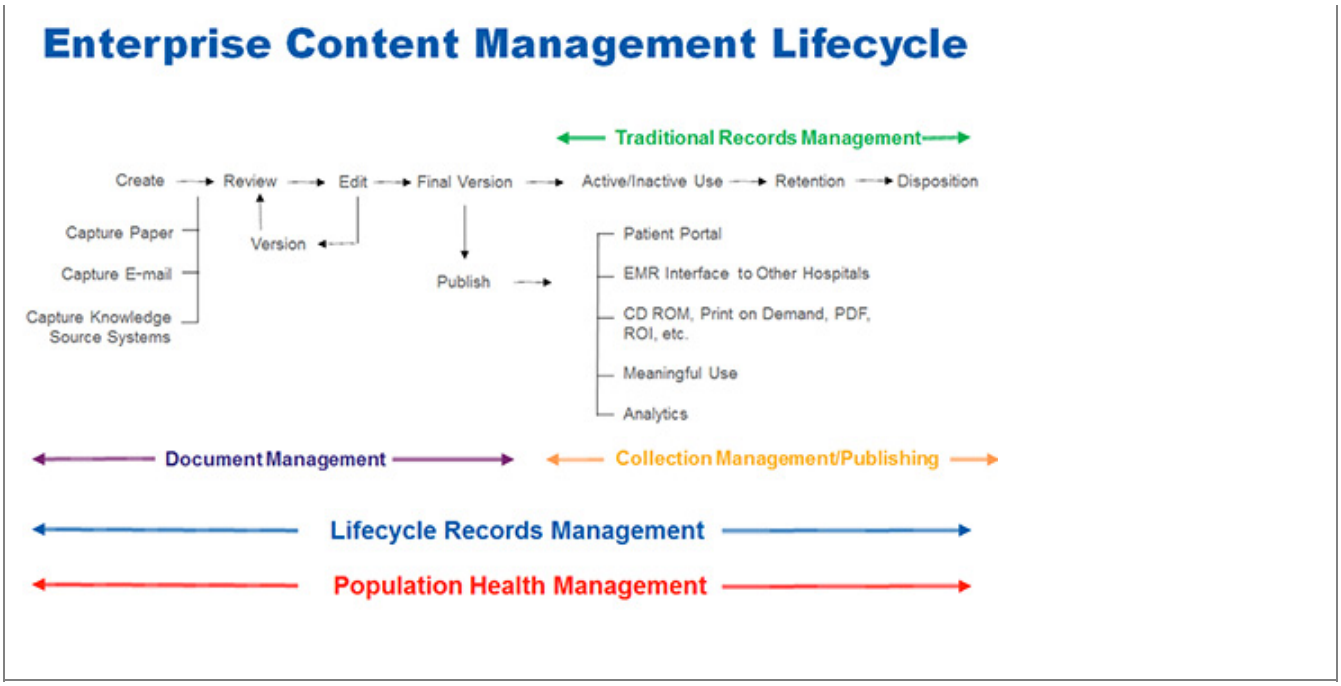
Given there was little published information regarding HIM departments who had successfully completed such a migration, the UM BWMC team was left with doing online research, contacting other HIM departments across the country, and developing what it believed was the next iteration of HIM—enterprise content management.

A *Journal of AHIMA* article from 2012 titled "Health Information Management 2025: Current 'Health IT Revolution' Drastically Changes HIM in the Near Future" made a compelling case for the radical change HIM must go through with the implementation of the EHR. Four years later this revolution continues in spite of some of the HIM profession's best efforts to resist. After all, change is hard and "this is how we've always done it."

In order to see where the profession should go, let's first examine where HIM is today compared to the reality outlined in the above *Journal* article (the authors of this article would encourage all readers to review the "Health Information Management 2025" article, as it was prophetic in its description of where HIM is heading).

HIM Today vs. 30 Years Ago

Below is a data visualization of what HIM looked like some 30-plus years ago versus today. Thirty plus years ago, the Medical Records department operated under a "traditional records management" structure. HIM was more concerned about whether the file was active/inactive, how long to retain it, and when it could be disposed of. Today there is no longer an isolated medical record in one facility. As data from electronic health records are available in real time via patient and hospital portals, HIM departments are now in the publishing business. Sophisticated skill sets not normally residing with HIM professionals are being required to oversee the information management process as well as related business intelligence software.[1]



HIM a Late Adopter to Tech, Thought Leadership

The healthcare industry, and HIM in particular, is a late adopter of new technology and new thought leadership. AHIMA and other nationally renowned professional organizations have been writing articles as far back as 2008 discussing the importance of not only adopting new EHR technology, but redefining HIM and how the profession looks at patient data. Unfortunately, HIM professionals did not truly understand the process revolution that needed to occur hospital-wide in order to leverage this new technology to its greatest potential.

What the HIM industry didn't realize until now is that:

- There is currently a fragmented and often chaotic process for managing the patient's medical record in a real-time world; very few understand it end-to-end.
- Industry metrics for managing clinician documentation are based on standards set decades ago in a paper world.
- While many have driven down the delinquency/deficiency rates to Joint Commission-acceptable levels, there has been almost no impact on the quality of the documentation. The industry simply automated the old documentation processes already in place.
- The need for a comprehensive, stringent process in release of information departments is stronger than ever with the implementation of an EHR and the different ways it allows the release of information at a facility level and enterprise level, along with the third party interhospital sharing of patient data.

These issues are concerning. After all, as the saying goes, "change is inevitable, growth is optional." HIM professionals don't have the option of standing still. As the October 2008 *Journal of AHIMA* article "Enterprise Content and Record Management for Healthcare" states, "The requirement to better manage electronic health information, and the dearth of management strategies to help the healthcare industry demands such as e-discovery, has highlighted the need for an overarching strategy to aggressively manage records and content."

HIM is Comfortable in the Old Paper World

Historically, HIM professionals were trained to manage an exclusively paper-based documentation process. They were not given a strategy for migrating from a paper-based world to an EHR world, let alone a strategy on how to excel in that world. They have had little or no formal training in data management, data governance, or enterprise content management.

Given that nothing different has been developed in terms of metrics, HIM directors are left to their own devices on how to effectively and efficiently manage an EHR that practically offers real-time access to information.

In comparison, departments such as Patient Access, Patient Accounting, and Finance have been electronic for decades. HIM is now thrust into the electronic age—which it will need time and patience to master.

Business Drivers for an Enterprise Content and Record Management Strategy

Doing nothing or doing what HIM has always done is not an option for the industry—and was not an option for UM BWMC. The HIM department at UM BWMC has been exchanging EHR information with just about every state in the US, including hundreds of hospitals and thousands of physicians—not to mention the patients themselves. The health system is now getting intelligence that other outside hospitals and physicians are acting on shared documentation and problem lists when treating shared patients. UM BWMC staff have determined that there are clear factors that call for a migration from a traditional HIM approach to managing the patient's medical record to a comprehensive enterprise content and record management strategy that encompasses a focus on:

- Patient safety and quality of care initiatives
- Documentation—complete, accurate, and timely documentation of a patient's episode of care at time of discharge
- Legal and regulatory compliance: Correct and complete legal medical record
- Accreditation and regulatory standards: Multiple systems housing data
- Analytics: Developing key insights, enabling population health management across the enterprise

Forget deficiency and delinquency tracking. Forget the 30-day rule to getting documentation done. This is based on a decades-old standard of working with paper when it took 30 days to get the chart to medical records, decompose the chart, flag it, and have once-a-month parties to get the doctors in to get their documentation done.

One of UM BWMC's lessons learned from their transition is that HIM can drive its delinquency percentage to below five percent, but at the same time have zero impact on the quality of clinical documentation. The problem is that HIM professionals have been "hard wired" to track the delinquency percentage. Yes, the department can meet or exceed Joint Commission requirements for the metric, but at the same time lose sight of the quality of clinical documentation within the patient's chart.

The authors of this article believe the new standard should be that all clinical documentation, regardless of note type, must be finished by the day of discharge. In the age of a "just in time" healthcare economy, 30 days is a lifetime.

HIM is no longer a department—it is a concept. A new data model requires new concepts and definitions. Terminology such as deficiency and delinquency are clerical terms denoting that a piece of documentation is missing or a piece of documentation has exceeded its stated time limit boundaries. In the new electronic world, patient safety and quality of care must be healthcare's number one concern. As such, HIM should reclassify the lists it publishes around missing discharge summaries, missing operative reports, unsigned verbal orders, etc., as "Open Patient Safety Lists" to create an appropriate sense of urgency and resolve these issues on or prior to the patient's discharge.

HIM is transitioning from a model where only individuals certified as an RHIA/RHIT are recognized as experts, to gradually understanding the need to collaborate with other professionals who may not be certified but understand the nuances of healthcare data analytics and how it may be clinically employed. This may be hard for some in HIM to accept.

Another painful growth area is moving HIM from an internally focused organization to one which is externally focused. A real area of opportunity for HIM directors is creating multidisciplinary teams to attack patient data issues, documentation issues, etc.

HIM departments are gradually coming around to moving HIM professionals, and other data professionals, out into the nursing units to interact and problem solve in real time. UM BWMC plans to do this soon.

With clinical documentation happening in real time and in force, the need for HIM data professionals on the units to assist clinicians is paramount. They can advise on the correct process for documenting patient care actions and interventions from beginning to end. This may include:

- Reducing the number of verbal orders, increasing use of order sets
- Reducing the number of verbal orders assigned to non-credentialed physicians
- Reducing the number of declined verbal orders
- Timely sign-off of verbal orders

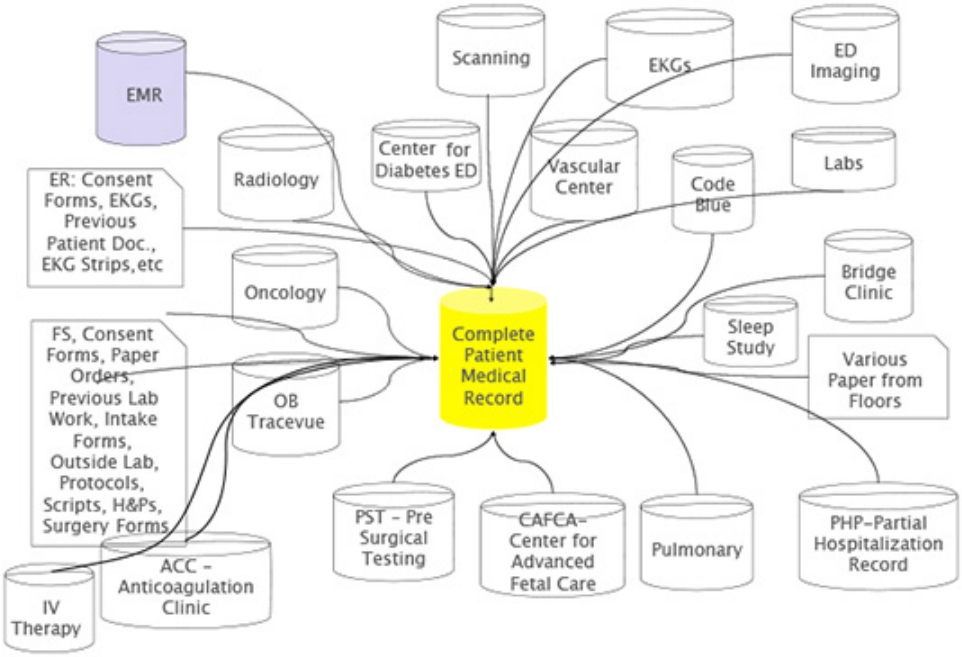
UM BWMC has found nursing and physicians have been very accepting of having real-time HIM assistance with their issues.

A great way to get at the heart of issues surrounding the EHR is a discussion on accommodation versus accountability. One can have an EHR that practically drives itself, but it won't be successful until the physicians and leadership teams are also moved along this change continuum. This has been the toughest issue UM BWMC has faced with the implementation of its EHR. Traditionally, UM BWMC's HIM staff has let physicians get away with numerous small infractions when it comes to documentation, verbal orders, and compliance with HIM policies and procedures since HIM needed physician support and didn't want to upset them. HIM staff has also tended to monitor non-compliance with a "rear view mirror" approach. This might have worked in a paper-based system, but it will no longer work with today's EHR, which demands more immediacy. Physicians and clinicians need to be held to a higher standard of complying with established documentation standards, policies, and procedures. For those who can't, corrective action must be taken to ensure a culture of accountability. HIM professionals have to be accountable for the quality and completeness of the data that's published.

Finally, the healthcare industry has begun seeing some unintended consequences of the "meaningful use" EHR Incentive Program. With federal dollars being paid to incentivize hospitals to implement EHRs, there has been some backlash in the process. Some in the healthcare industry feel the country ended up with EHRs that were "utilized" but not very "useable" due to lax standards and guidance from the meaningful use program. For example, it was common that EHRs were installed with little thought for "end-to-end processes." The clinical documentation side of the hospital may decide to add a new form, not realizing that on the HIM side of the hospital the print form function has to be modified to include the new form. "We're all in this together" has never been a truer phrase for HIM.

Integrated Patient Medical Record Proves Elusive

The EHR environment will continue to morph from systems loosely held together to a truly integrated patient medical record. Below is a graphical depiction of what UM BWMC's current EHR environment looks like: electronic and paper. The EHR is not perfect; it is still a work in process. All constituencies should have a vested interest in how all of this fits together as UM BWMC moves forward to perfecting the EHR. It has to be a combination of people, process, and technology to make it all work. In the spring of 2017 UM BWMC will be upgrading the EHR to reduce the number of external feeds.



Time to Change

Regardless of the challenges outlined above in implementing the EHR and reinventing HIM to evolve into enterprise content management, there is a tremendous amount of opportunity to improve the process of documenting the care of a patient to increase the documentation accuracy and timeliness, which improves patient care, increases patient satisfaction, and decreases costs. All patient documentation is being published in some fashion locally, nationally, and, perhaps, internationally. HIM is poised to play a vital role in developing an overall enterprise content management strategy to ensure the accuracy and integrity of the information is maintained.

All constituencies should recognize and accept the challenge of accommodation versus accountability, and take the appropriate steps to improve the process as opposed to HIM traditionally reporting out compliance/non-compliance numbers with no follow up plan or action. This is a journey, not a destination.

UM BWMC Case Study

Approximately two years ago, staff at UM BWMC had an epiphany. They had driven their delinquency percentage down to five percent, but their clinical documentation was poor at best. The feedback staff received across the board was that their discharge summary needed to be completely redesigned. In response, an interdisciplinary team was created, which included HIM, hospital-employed physicians, private practice physicians, as well as the Informatics, Care Management, Revenue Cycle, CDI, Quality, and Coding and Process Improvement departments. Through an interdisciplinary approach, UM BWMC

developed a discharge summary template that everyone could live with, and are getting ready to pilot it in 2016. See the template below.

University of Maryland Baltimore Washington Medical Center Discharge Summary Template

ALLERGIES: Auto populates
Patient Name: Auto populates
DOB: Auto populates
Admission Date: Auto populates
Discharge Date and Time : Auto populates

CODE STATUS: Auto populates
MRN: Auto populates
Admission Date: Auto populates
Patient's Primary Contact Number: Auto populates

Diagnosis

List of Diagnoses: Physician narrative

Functional and Cognitive Deficits: Auto populates

Important DME Needs: Auto populates

Physicians

PCP: Auto populates

Treatment Team: Auto populates

Hospital Course (Please include diagnosis tested and ruled out for diagnosis, sequential changes in therapy, reason for home medication discontinuation and alteration, significant procedures including outcomes and recommendations, and ordered consults.)

Physician narrative

Procedures: Auto populates

Significant Lab and Radiology Findings

Physician narrative

Discharge Status

Condition: Auto populates

Disposition: Auto populates

Discharge Medications

Auto populates

Next Steps and Recommendations

Diet/Activity/Dressing Care: Auto populates

Care Management or Home Health Needs: Auto populates

Appointments: Auto populates

Pending Tests on Discharge: Physician narrative

Pertinent information for community provider: Physician narrative

Recommended outpatient tests: Auto populates

Total discharge planning, communication/discussion and coordination of care today was greater than *** minutes.

Note

1. AHIMA. "Enterprise Content and Record Management for Healthcare." *Journal of AHIMA* 79, no. 10 (October 2008): 91-98.

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