Simplified Deficiency Processing Brings Hospital-wide Benefits

by Darice Grzybowski, MA, RHIA

Editor's note: This project received third prize in AHIMA's first annual Best Practices Award Contest.

Unhappy physicians, frustrated HIM staff and an administration looking to cut costs led to a major overhaul of a hospital's incomplete record processing practice. By taking full advantage of new technology and adopting an innovative approach to processing deficiencies, the hospital saved money and time. Here's how they did it.

Incomplete and delinquent medical records are a chronic problem for both clinicians and the HIM professionals who monitor them. Unfortunately, antiquated guidelines are still used by accreditation agencies like the Joint Commission on Accreditation of Healthcare Organizations, which readily admits that the documentation requirements have changed little since the 1920s. Further, various archaic laws related to record processing are still common across the United States and inherent in the Medicare Conditions of Participation. These guidelines and laws are not easily changed and reflect neither current practices in healthcare nor the changes in technology. As a result, HIM professionals have the opportunity to develop creative ways to more efficiently process records as practice patterns in medicine and documentation change.

Hinsdale Hospital, an acute care/tertiary teaching hospital in Hinsdale, IL, addressed this problem with a three-part solution. By installing a computerized chart-tracking and deficiency system, streamlining the filing process for incomplete records, and increasing accountability among clinicians for delinquent records, the hospital realized substantial savings in physician time and HIM staff and increased concurrent record completion. Here's how it was done.

Recognizing the Need for Change

Faced with growing numbers of incomplete records, increasingly dissatisfied clinicians unable to keep up with excessive documentation requirements, and pressure to reduce labor costs, Hinsdale administration and medical staff leadership requested an alternative approach to traditional record processing.

Administration, HIM staff, and clinicians identified several problems with the incomplete record processing system and identified how modern technology was changing documentation:

- Retrospective documentation practices allowed, and in some cases encouraged, delayed documentation critical to patient continuity of care and reimbursement. Often, necessary documentation occurred months or years after patient discharge

- Attempts to comply with unreasonable guidelines, such as the authentication of every entry within certain amounts of time, were unrealistic, costly, and even fraudulent. Many hospitals allow signatures to be added as entries in medical records after discharge not as "late addendums and corrections" and without verification of content and or placement of date or time. Hospitals use this technique to make orders and reports appear as if they had all been authenticated in a timely manner. Blatant use of rubber signature stamps in some facilities demonstrates this practice at its worst

- "Suspension" or "off beds" policies were punitive in nature, usually unenforceable, and typically did not distinguish between physicians with an occasional problem, and those with chronic problems. Further, these policies did not take into account individual practice patterns and volumes

- Continual handling and processing of records, such as repeatedly flagging for signatures, was labor-intensive and led to manual errors due to the sheer volume of checks and balances

- Shorter patient stays, growing volumes of documentation due to point-of-care systems, loose/late reports due to other automated systems, and increasing shifts to outpatient care settings contributed to greater workload demands on clinicians, and the need for documentation efficiency

- Digital dictation, imaging, and point-of-care systems, clinical repositories, remote access viewing, and fax machines created alternate methods of document review and verification and eliminated the need for verification of every notation

- Continuous quality improvement measures were adopted that required the authenticity and accuracy of clinical entries to be defined at the time of entry origination, or authorship, and identified through use of defined statistical process control-oriented audits

After dialogues with clinicians and staff about their needs and wishes for documentation policies and procedures, a plan to revise the current incomplete and delinquent record processing practice into one that embraced a "less is better" philosophy was developed.

Objectives included:

- reduce the number of incomplete and delinquent records
- reduce the amount of time clinicians spend completing records retrospectively and encourage concurrent record completion
- reduce the amount of labor necessary to support record processing functions
- provide more meaningful statistics and data trending regarding incomplete and delinquent records
- eliminate the customer-unfriendly and unenforceable "suspension" policy
- eliminate the need to bring patient records to be filed as incomplete to a committee for approval

Taking Action

To meet these goals, it was clear that we needed to revisit the policies and procedures on clinical pertinence, electronic signatures, and record completion. At the same time, we needed to educate the medical and HIM staffs about the changes ahead.

We made several presentations to the medical staff about the limited value of retrospective verbal order signatures. Despite the staff's initial reluctance to move to non-traditional quality monitoring from chronic "tagging" of deficiencies, the physicians began to view documentation as a critical part of patient care that needed its own special set of monitors and indicators. To provide objective data, we reviewed 20,000 retrospectively tagged and unsigned orders over several months. The cost of signing those orders was estimated at $40,000 worth of physician time and a fourth of full-time employee staff time. Of those verbal orders, no orders were altered or corrected and no dates or times were added to any entry, making it impossible to distinguish between retrospective and concurrent signatures.

After presenting this data to the medical staff, it was conclusively agreed that this activity added no value to the facility or patient care issues and was to be discontinued. However, concurrent flagging of orders and the desired requirement to have orders authenticated while the patient care is still active was still encouraged. (Note: Illinois has since changed its regulations to relax the 24-hour ruling, pursuant to extensive joint lobbying by the Illinois Health Information Management Association, the Illinois Hospitals and Health Systems Association, and the Illinois State Medical Society.)

Other barriers to overcome were the resistance to change and "gray" areas in law or standards that needed to be accommodated in policy and procedural wording.

Implementing the Change

The first decision was to install a computerized chart tracking and deficiency system. Then, with the assistance from the IS department, SQL downloads, Lotus spreadsheets, and Paradox databases were used to create databases and reports. These

applications are designed to meet the needs for information reporting to manage the incomplete record flow and statistics.

To simplify the processing of incomplete records, only the items designated as "critical deficiencies" by the medical staff (i.e., missing H&P, operative report, discharge summary, consultations, or other clinical reports) in a patient record resulted in incomplete status. Because completing records retrospectively demanded so much time, signatures on items other than these "critical reports" would no longer be monitored retrospectively. To encourage concurrent completion, unsigned orders would be flagged when taken by the receiving party, usually an RN. If any unsigned orders remained at discharge, the records were considered correctly administered and needed no further authentication.

Bringing a list of chronically incomplete records due to critical deficiencies to a standing committee to "deem as incomplete" is a common practice in most facilities. Instead, it was decided to automatically file records still remaining as incomplete 45 days after discharge on non-completion.

When purging and filing these records into permanent file, a stamp indicating what is being filed as incomplete and why is placed on the record. These become the numerator or indicator by which one is able to measure the success or completeness of the record. At any time, a clinician may request a record to be taken out of permanent file and attach an addendum to the record, thus "voiding" the incomplete stamp and ensuring the record documentation is appropriately timed and dated as an addendum entry.

Addressing Documentation Requirements

Under the new delinquent process, incomplete face sheets would no longer be considered a deficiency unless a physician did not document final diagnoses and procedures elsewhere in the record. A summary of final coded diagnoses and procedures is kept on each record and a copy provided to the attending physician on a routine basis.

Discharge summaries are to be completed by the physician before delinquency begins as defined by the Joint Commission (31 days after discharge). However, if not completed by the attending physician, they are assigned to another physician to perform dictation for a fee. The service fee is then charged back to the medical staff member, which is payable upon renewal of dues to the medical staff on a yearly basis. This is coordinated by the HIM staff, who assigns the discharge summaries, the finance department, which pays the "volunteer physicians," and the medical staff office, which coordinates the collection of fees from the medical staff members and the reimbursement back to the hospital from the medical staff treasury of funds.

Statistics and Accountability

On a weekly basis, each physician or ancillary department receives an automated list of all patient records with any critical deficiency and the date which that record becomes delinquent. Thus, the average incomplete record appears at least three times on a notification list to the responsible party prior to delinquency at 31 days post-discharge. Medical staff are advised to complete all records at least once every two weeks to avoid records filed as incomplete. On the 45th day, all records still delinquent are purged, logged in a database, and "filed" as incomplete.

On a monthly basis, medical staff department chairmen receive a detailed delinquent list and graphs by department, physician, and type of deficiency. These graphs generally demonstrate that 10 percent of the physicians are responsible for 80 percent of the delinquent records and to allow counseling to take place before problem patterns develop. All communication regarding any discipline is the sole responsibility of the medical staff.

Quarterly and annually, the department chairmen and credentials committee receive a summary of all records "purged" by deficiency type, which reveals the true delinquent record count based on uncompleted records by department and individual physician (see "Records Purged for Deficiencies"). The report also contains a percentage comparison of activity level of each physician to the number of delinquent records.

The medical staff has recommended disciplinary action if a pattern of more than 10 percent activity level of records are considered to have aged to delinquency and been purged with critical deficiencies. Recommended forms of accountability for the medical staff may include verbal or written counseling by the department chair, with copies in the medical staff credentials file, a request for explanation of record completion problems by physician in front of the medical staff executive or quality committees, suspension of privileges, or nonrenewal or lessened renewal of privileges to the medical staff.

Less Is Better

Since this program began in 1992, final delinquent record percentages have averaged no more than 3 percent of total discharges based on activity level of the various physicians. The hospital has saved more than $50,000 in physician time and HIM staff FTE annually. Because the training and technology solutions were implemented in the facility as part of normal workflow, there were no additional expenditures, only net savings. HIM staff and physician relations improved dramatically due to innovative partnership by using technology and creativity to manage an age-old problem.

Further, error rates in assignment of deficiencies have been reduced due to decreased handling of the records by HIM staff and clinicians. Overall, productivity has improved, and shorter coding turnaround times lead to quicker reimbursement.

Additional and unexpected positive results included the increased accountability of the medical staff to complete what was "critical" once signatures were eliminated from the retrospective responsibility. These more complete patient records led to greater satisfaction among the physicians and a perception of better patient care. Other positive documentation changes grew out of this initiative, including the implementation of a uniform chart order and standardized chart dividers.

One down side was that greater numbers of discharge summaries were left delinquent post discharge due to less frequent retrospective visits to complete records from the practitioners. Thus, greater numbers of "volunteer" physicians were needed to moonlight for completion of these summaries. There were also a surprising number of physicians who missed the "nag" notes, phone calls, and suspension lists of the traditional completion systems and who couldn't adjust to a non-punitive record completion style. These physicians initially tended to have more records filed as incomplete, but after education, they showed improvement.

Continued Monitoring for Ongoing Improvement

The effectiveness of this practice was measured by verbal feedback from the medical staff as well as customer satisfaction surveys of other departments and the medical staff, both of which received exceptional rankings. The practice is monitored by medical staff, administration, HIM department, and external agencies. After several Joint Commission surveys and one Department of Public Health survey with support for this method of monitoring deficiencies, the program was viewed as a success.

The HIM department continues to assess this situation via the quarterly delinquent reports and monthly meetings with the chief medical officer to monitor satisfaction levels. Led by the vice president of nursing and the chief medical officer, the recently established clinical documentation committee monitors results of clinical pertinence audits, including quarterly verbal order signature audits, and delinquent counts to provide feedback on any noticeable trends.

Periodic evaluations are performed, based on audit and review cycles. These results are used as part of the ongoing performance improvement cycle and as part of the required CQI process mandated by the Joint Commission. Others in the profession may benefit from decreased frustration, improved efficiency, and excellent application and use of technology.

Before Getting Started

Before undertaking a change like this, remember one thing: Don't underestimate the power of "culture" and "tradition." It's important to allow people to change in their own time, and when they are ready. At the same time, it is the HIM professional's job to provide information and the influence necessary to achieve the goals of advocating quality and cost-effective healthcare documentation.

Using AHIMA's House of Delegates resolution on this issue and other related practice statements, which did not exist at the time we initiated this change, would assist HIM professionals in implementation. It's also important to involve an administrative champion in a strong role, in addition to members of the medical and HIM staffs, so that these improvements can be facilitated more rapidly.

Summary of Physician Documentation Delinquency

Records Purged for Deficiences
First Quarter Statistics

Medicine Department

Physicians	Deficiency Type	# Incomplete	Total Cases As		% Incomplete
#1	Hist. & Phys.	4	Attending	185	2.2
#2	Hist. & Phys.	1	Attending	400	.03
#3	Hist. & Phys.	2	Attending	62	3.2
#4	Hist. & Phys.	1	Attending	29	3.4
#5	Hist. & Phys.	1	Attending	11	9.1
#6	Operative Rpt.	1	Surgeon	6	16.7
#7	Consultation Rpt.	1	Consultant	16	6.3
#8	Consultation Rpt.	1	Consultant	4	7.1
#9	Consultation Rpt.	1	Consultant	21	4.8
#10	Hist. & Phys.	4	Attending	19	21.1
	Totals:	**17**		**763**	**2.2**

Hospital Totals (Inpatient) for Period - 57 Physicians

Deficiency Type	# Incomplete	Case Type	# of Cases	Joint Commission Threshold (%)	% Incomplete	Variance between JCAHO & actual (%)
Consultation	18	Consultant	22,924	2.00	.08	-1.92
Hist. & Phys.	71	Attending	16,960	2.00	.42	-1.58
Operative Rpt.	43	Surgeon	14,227	2.00	.30	-1.70
Other	54	Attending	16,960	2.00	.32	-1.68
Totals	**186**		**54,111**	**2.00**	**.34**	**-1.66**

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