Health Record Analysis

As discussed in earlier chapters, the patient health record is a compilation of general and specialized health record forms and documents that contain specific patient care information. To help ensure that the health record and its component forms and documents are complete, the HIM department may conduct an analysis, or review, of the record. This chapter describes the traditional, detailed approach to health record review (performed after patient discharge) and the newer, more focused and concurrent approach (performed during the patient’s stay in the institution).

It is important to note that in reviewing the health record for documentation adequacy, the HIM professional does not render judgments or assessments regarding the quality care. That task is performed by peer groups of health care providers. However, the HIM professional’s review of documentation plays an important role in the assessment of clinical quality. Such evaluations of record thoroughness, timelines, and accuracy indicate the degree to which it will useful for gauging the quality of care provided. A complete record also supports patient care and expedites the billing process.

MAJOR STEP IN HEALTH RECORD ANALYSIS

Health record analysis, sometimes know as discharge analysis or postdischarge analysis, refers to the tasks involved in processing the health records of discharged patients. Health record analysis helps to ensure that records are complete, accurate, timely, and legible, and that patterns of documentation among physician and other health care providers are noted and assessed. Major tasks typically performed during the analysis include review of admission, discharge, and transfer reports; assembly of forms and documents within the health record folder; and qualitative analysis of record contents.

Task Associated with the Admission, Discharge, and Transfer report

To track patients, health care facility information systems generate a daily admission, discharge, and transfer (ADT report, which is a lists patients who have been admitted, discharge (including those who died), or by name, bed number or location, and health record number. This list is distributed internally to the HIM department and to various other departments.

An accurate ADT report is an essential tool for many HIM departments performing quality assessment. The HIM department uses its copy of the ADT as a checklist to ensure that all records of discharges and deaths have been received or otherwise accounted for. Records of previous admissions that have been forwarded to the nursing station for review during care must also be returned to the HIM department for proper filling. Furthermore, the computerized or manual master patient index (MPI) must be updated to reflect recent discharges, deaths, and transfers.

Record Assembly
Upon a patient’s discharge, HIM department staff may assemble the patient’s health record in an established order. Patient records at the nurses’ station are typically maintained in reverse-chronological order to facilitate continuous updating and reference requirements. After the patient is discharged, the HIM department staff member may reassemble the record in an established sequence that is more conductive to future, ongoing use. The established order is one accepted by the medical staff (or its medical record committee), in corporation with the health care facility administration. It is often referred to as the chart order or health record format for permanent filing. The patient record typically also includes any ambulatory care or outpatient services forms within this single, or unit, record.

The word permanent refers to the length of time that health records are to be maintained in their original or nonminiaturized form. The health record is kept in the permanent active file until it is scanned, microfilmed, placed in an inactive file, or properly destroyed after the required retention period.

The permanent health record is arranged in its component parts (medical, ancillary services, and nursing); with either reverse chronological or chronological filing within each component, usually according to the source-oriented format. (Recall from Chapter Two that in the source-oriented format, each department documents care within its own section of the record.) If the integrated formed is used, all forms are organized in date order, and those from various source are intermingled. No matter what format is selected, the format should promote an ease of referencing needed information.

To save time and money, some health care facilities choose to perform a modified assembly or not to reassemble the record at all. In a modified system, major section are assembled, but a strict dare order is not required. If the health care facility chooses not to reassemble the record after patient discharge, it is said to be using a universal chart order. This means that the medical staff, nursing, and the HIM and other involve departments have agreed on an order that is used while the patient is in-house; the order will remain the same after discharge, including for permanent filing.

When universal chart order is used, two options are available for the HIM department in handling the record after discharge. The first is to file the record exactly as it is received from the unit. The unit clerk is usually responsible for ensuring that the record is in the agreed-upon order and for removing any unnecessary forms or copies. The other option is for the HIM department staff to verify the order and remove any copies or unnecessary forms. The HIM department staff also reviews each form and report in the record to ensure that it belongs to the indicate patient. The assembly method that is chosen depends on anticipated needs for future retrieval of the information.

Overview of Quantitative Analysis
Quantitative analysis is conducted to determine the accuracy and completeness of the health record. HIM professionals who have oversight responsibility for assembling the records of discharged patients perform a quantitative analysis function to determine the presence or absence of essential reports and items such as the following:
- Discharge summary or clinical resume
- History and physical examination report (H&P)
- Authentication (signatures) for designated entries in the health record (for example, progress notes, physician’s orders, and operative reports)
Principal and additional diagnoses and principal and additional procedures documented by the attending physician
Operative report, preanesthesia and postanesthesia reports, and pathology report for patients requiring surgery
Reports of all diagnostic tests or studies ordered (for example, laboratory, radiology, EEG, and EKG)
Authenticated consultation reports (if a consultation was requested)
Signed authorizations and consents
Correct patient identification on every paper form or computer screen
Complete and authenticated reports that are required for patients in units such as obstetrics, neonatal, and rehabilitation
A more detailed description of the documents and data collected during the quantitative analysis appears later in this chapter.

Deficiency systems. To note the absence of materials or items, the HIM professional may use a manual or a computerized deficiency system. With the manual system, the HIM professional compares the contents of the health record with a checklist. Should reports or signatures be missing, the HIM professional tags the health record folder with a slip that specifies the deficiencies and the physicians or staff members who are responsible for correcting them. Missing signatures are typically indicated in the record with a colored clip or tag, with the color indicated next to the responsible physician’s name on the deficiency slip. When the record is completed, the slip is removed and discarded.
With a computerized deficiency system, the deficiencies are entered into a computer a specialized program. The program tracks the deficiencies for each record, which is updated as the deficiencies are completed. The program also tracks the number and types of deficiencies by physician. Most programs also generate the reminder letters sent out at predetermined intervals, notifying the physicians of any incomplete or delinquent medical records. Management reports are available that indicate the deficiencies by type (for example, missing discharge summaries, missing physician order signatures) and number. Reports can list responsible physicians by name, with the type and number of deficiencies for each.
Implementation of an electronic health record drastically changes these functions. Record assembly is no longer performed. Quantitative analysis is still necessary, but the authentication of report is changed. Software for maintaining electronic records contains documentation prompts, built-in edits, and other mechanisms designed to ensure that the record is complete at the point of data entry.

Deficiency Follow-Up Activities. Often the HIM professional must follow up on deficiencies identified during the analysis process. For example, he or she may investigate late or missing diagnostic reports, or examine specific issues (for example problems on the nursing unit in entering patients’ reports into the health records) during department or institutionwide quality-assessment studies. In addition, the HIM department director incomplete and delinquent medical records, the type and number of deficiencies, and physicians responsible for correcting them. It is also good practice to closely monitor the length of time that each record has remained incomplete. This report is then distributed to the respective physicians, the medical record committee, the chief of the medical staff, and the health care facility administer or vice president to whom the HIM director reports.
Overview of Qualitative Analysis

Qualitative analysis is the process involved in checking the content of the health record to identify inconsistent or inaccurate documentation. Thus the record is reviewed for accuracy and adherence to documentation procedures and standards rather than for the presence or absence of forms and signatures. As a result of the review, the record is found to be complete and accurate or incomplete and inaccurate.

Qualitative Analysis and the Quality Assessment Study. Often the qualitative review is the by-product of quality activities that are performed to assess patient care. For example, HIM professionals who assist the medical staff in abstracting the health record for compliance with quality-of-care criteria sometimes find that the recorded information is inadequate for the purpose. This discovery prompts an investigation into the reasons for the inadequacy. The findings of the investigation can be useful to the medical record committee and the quality assessment committee in promoting better documentation in the health record.

Qualitative Review Checklist. Another approach to qualitative analysis is to develop a checklist of significant points to be reviewed for documentation. Such a list might be developed by the HIM professional in cooperation with the medical record committee or a representative group of the medical staff and other professional staff. The following list provides examples of questions asked in the qualitative review of health records:

- Does the admitting process consistently and accurately gather demographic data for inclusion in the patient health record?
- Does the history of present illness reflect the patient’s own words?
- Does the patient’s history include references to any past problems or to problems in the family history? Does it include a review of body systems as required in the criteria established for qualitative review?
- Do physicians’ orders reflect the clinical problem for which each service or item is ordered? Is there evidence that every order was carried out?
- Do the physicians’ progress notes describe the patient’s problems, his or her clinical state of comfort or distress, and the reasons behind the therapeutic decisions?
- What is the turnaround time, or TAT as it is commonly referred to, of the dictated reports? TAT is the time lapse between dictation and transcription of the H&P, operative reports, and other dictated reports. Do the reports reflect the dates of both dictation and transcription?
- Do the nurses’ notes meet the criteria established for quality review of documentation? Are there time gaps in the record, or does the record reflect the general location of the patient at all times during the hospitalization?
- Are the health care facility guidelines for error correction followed?
- Are the rules for using symbols and abbreviations followed?
- Are there inconsistencies in the diagnoses noted throughout the record on the admitting forms, H&P report, operative report, pathology report, and discharge summary of clinical resume?
- Does the patient’s pharmacy drug profile match with the medication administered to the patient?
- Does the record reflect the discharge instructions given to the patient or the patient’s family member’s understanding of these instructions?
By answering these and other questions, the HIM professional can pinpoint problems, such as the need for better information-capture tools, faster TAT in transcription, and corrective action in documentation.

Document and Data Reviewed During Analysis
As describes in the previous overviews of quantitative and qualitative analysis, the HIM professional checks a variety of documents for their levels of completeness and accuracy during this two types of review. The subsections that follow highlight specific documents and data collected or reviewed during both processes.

Admission records. The front sheet, also known as the top or face sheet, of the patient record contains a variety of information. Information entered by the admitting department and contained in the patient identification section of the front sheet varies in amount and specificity among health care facilities. The basic patient data that are required include name, address, health record number, age, date of birth, sex, race, marital status, religious preference, name of nearest relative, and nearest relative’s address and telephone number. Also included on the front sheet is the admission date, room location or nursing unit assignment, source of payment, attending physician’s name, type of admission, and admitting diagnoses or diagnosis. The HIM department may eventually add the discharge date, and any transfer of physician or clinical service may be noted as it occurs during hospitalization. For emergency admissions, the admitting staff does not always have access to all patient identification formation. Missing information is added as it is received.

In addition, all pages of the health record must identify the patient by name, health record number, and nursing unit or room number. Typically, this information is computer-generated and printed on each form as it is produced.

The Discharge Summary and the Transfer Summary. The discharge summary, also called the clinical resume, is a concise recapitulation of the patient’s course in the health care facility. According to the Joint Commission, the discharge summary should contain the following items:

- Reason for hospitalization
- Significant findings
- Procedures performed and treatment rendered
- Patient’s condition at discharge
- Instructions to the patient and family, if any

All relevant diagnoses established during the course of care, as well as all operative and other invasive procedures that are performed, must be documented. This documentation must be entered in acceptable disease and operative terminology that includes etiology. A final progress note may be substituted for the clinical resume for normal newborns with uncomplicated deliveries or patients with minor medical problems who require less than a forty-eight-hour period of hospitalization. The medical staff defines what medical conditions or problems are considered minor. The progress note may be handwritten or dictated. A discharge summary or final progress note must be completed and signed within thirty days of patient discharge.

It is imperative that the physician document the principal diagnosis, secondary diagnoses, principal procedure, and additional procedures in each record before the record is coded. If the diagnosis or procedure is not listed but substantiated in the record, it must also be documented. The HIM professional must refer to the physician
for clarification of any record in which a listed diagnosis or procedure is not substantiated or documented.

Although no accreditation standards of federal regulations have a specific time requirement for completion of the discharge summary, it should be noted that the entire record must be completed within thirty days of discharge in some facilities, physicians may have the option of contracting with outside services offered by health care professionals, such as credentialed HIM professionals, who dictate the requisite information for the discharge summary. The physician then attests to the accuracy of the information by signing the summary. This system, which reduces the amount of time required to enter the discharge summary onto the record, is made possible when the record contains sufficient information for the HIM professional to perform the dictation.

Discharge instructions provided to the patient or family may relate to physical activity, medication, diet, and follow-up care. A copy of diet instructions that are provided to the patient is entered into the health record or maintained on file in the health record department of reference as necessary. A copy of the discharge plan that is prepared by the social service department is also included in the health record. When a patient is transferred within the same organization from one level of care to another, such as from acute care to a long-term care unit, a transfer summary may be substituted for the discharge summary. The transfer summary should briefly describe the patient’s condition at the time of the transfer and the reason for the transfer. When the caregivers remain the same, a progress note may suffice.

History and Physical Examination. The patient history consists of the patient’s chief complaint, a history of the present illness, relevant past medical, social, and family history, and a review of body systems. The physical examination should reflect a comprehensive, current physical assessment of the patient. The Joint Commission requires that the H&P examination by performed and documented by the examining physician within twenty-four hours of admission. If a complete history and physical examination was performed within thirty days before admission, a durable, legible copy of this report may be used in the patient’s health record, provided that any changes that may have occurred are recorded in the health record at the time of admission. A durable, legible copy of the office prenatal or antepartum record is acceptable for obstetrical records.

An interval H&P note is included in the record when a patient is readmitted within thirty days of discharge for the same or a related condition. The interval notation should describe any changes in health status since the previous complete history and physical was documented. The original H&P must be available for the physician. If the readmission is for a different condition, a new H&P should be recorded. The medical staff is responsible for determining those non-inpatient services such as ambulatory surgery for which a patient must have an H&P documented. Timely documentation of histories and physicals is important, whether the documentation is for an inpatient or an outpatient service.

Consultation Reports. A consultation is usually initiated by a written order or request from the attending physician or specialty department. The request states the purpose and the nature of the consultation that desired. The consultation report should include evidence of a review of the patient’s record, evidence of examination of the patient, pertinent findings of the examination, the consultant’s opinion, diagnosis, or impression, and recommendations for treatment. A consultation may take the form of
a separate consultation report are typically provided to the requesting physician and consultant; the original is placed in the patient’s health record.

Operative Reports. The preoperative diagnosis is entered in the record before surgery by the surgeon. Operative reports must be dictated or written immediately after surgery; they must contain the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and the postoperative diagnosis. The completed operative report is signed by the surgeon and filed in the health record as soon as possible after surgery. If a resident serves as the assistant surgeon and dictates the operative report, the primary surgeon is still responsible for authenticating it. When a transcription or filling delay occurs in the HIM department, a comprehensive operative progress note is entered in the health record immediately after surgery to provide pertinent information for use by any individual who is required to attend to the patient.

Anesthesia Records. A preanesthesia evaluation must be completed within forty-eight hours prior to surgery by an individual qualified to administer anesthesia. This evaluation includes at least a review of objective diagnostic data, an interview with the patient to discuss his or her medical, anesthetic, and drug history, and a review of the patient’s physical and emotional status.

The anesthesia record describes the monitoring of the patient, the dosage of all drugs and agents used, the type and amount of all fluids administered, including blood and blood products, the technique or techniques used, unusual events that occur during the anesthesia period, and the status of the patient at the conclusion of anesthesia. The anesthesia record must be signed by the anesthesiologist or anesthetist. Any unusual events or postoperative complications that arise, as well as the management of those events, must be recorded. The postoperative status of the patient is evaluated and documented on admission to and discharge from the postanesthesia care unit (PACU).

Progress Notes. Progress notes—signed, dated entries reflecting the course of the patient’s illness or injury during hospitalization—are the responsibility of the physician(s) and other authorized staff members. The frequency with which progress notes are written depends on the patient’s condition and the requirements of medical staff’s rules or guidelines. The health care facility may establish guidelines for the handling of records that do not contain progress notes regarding patients who are hospitalized for more than a specified number of hours. In such cases, the records should be reviewed by the medical record or quality improvement committee. The clinical pertinence review, which is a medical staff responsibility delegated to the HIM department, may also identify such documentation problems.

As noted earlier chapters, the Joint Commission has changed some of its requirements for authentication of some entries in the medical record. The health care does not specifically require signatures on progress notes, but the Medicare Conditions of Participation (COP) currently requires “prompt” authentication of health record entries, and individual state regulations may do so as well.

In the event of complicated hospital stays, progress notes must identify the complications and indicate the procedures and tests that are initiated, the types of problems being evaluated or ruled out, and the patient’s response to the treatment modalities. The physician’s progress notes should reflect a review of the documentation that is prepared by nurses and allied health practitioners.
Physician Orders. Physician orders direct a patient’s diagnostic and therapeutic course in the health care facility. Diagnostic and therapeutic orders are dated and authenticated by the responsible practitioner. Verbal or telephone orders are acceptable only if allowed in the medical staff rules and regulations and if accepted and transcribed by qualified personnel, as identified by title or category in the medical staff rules and regulations. The medication orders of unlicensed interns and residents may require countersignatures by a medical staff member. The medical staff should have a written list of orders that require authentication by the responsible physician within a designated timeframe. The Joint Commission no longer requires physician signatures on verbal orders, except those for medication ordered in behavioral health care. Note, however, that authentication is required by the Medication Condition of Participation (COP) and may be required by other accreditation agencies or by state laws and regulations. The HIM professional should work with the health care institution to develop organizationwide policies to ensure compliance with legal, regulatory, and accreditation requirements.

Pathology and Clinical Laboratory Reports. The signed and dated original reports of pathology examinations and laboratory test must also be placed in the health record. When tests are performed by outside laboratory services contracted by the health care facility, the name of the laboratory should be identified on the report placed in the patient’s health record. The pathologist, in cooperation with the medical staff, decides which cases are exceptions to the rule that all specimens removed at surgery must be submitted to the pathology laboratory; exceptional specimens require only gross description and diagnosis. The HIM department should aware of these exceptions. Most surgical pathology reports incorporate both gross and microscopic descriptions, with an accompanying diagnosis.

When an autopsy is performed anatomic diagnoses are typically recorded in the health record within three days, and a complete protocol should be made a part of the record within sixty days, unless exceptions for special studies are established by the medical staff. Data collected from autopsies should be shred with those responsible for improving health care facility performance. The data collection process itself must be guided by clear assessment criteria.

Radiological and Other Diagnostic Reports. Signed and dated original radiological reports, as well as other diagnostic reports, are also filed in the health record. The practitioner who interprets the film, tracing, scan, ultrasound, or other image authenticates the report. Only those individuals with delineated clinical privileges for interpreting diagnostic studies of performing therapeutic, invasive procedures are authorized to authenticate reports or studies and procedures. Any reports on preadmission diagnostic procedures should accompany the admission record to the nursing unit.

Medication Administration Records. The medication administration record (MAR) provides documentation of the medicines administered orally or topically by infusion, inhalation, or injection. The date, time, name of drug, dose, route, and signature or initials of the individual who administered the drug must be documented. Adverse drug reactions must also be documented in accordance with facility policies and procedures.
Nursing records. Clinical nursing records consist of information on patient assessments, nursing care plans, nursing diagnoses or patient needs, nursing interventions, and patient outcomes. The patient’s health record includes documentation of the nursing care that is provided, as well as patient’s response to it and to all other care. Nursing documentation includes many forms and formats, such as narrative notes, flowcharts, questionnaires, checklists, and graphics. Nursing forms may be paper-based, computerized, or a combination of the two. Nursing documentation in the health record should be pertinent and concise, and it should reflect the patient’s status. In so doing, it documents the patient’s needs, problems, capabilities, and limitations. The patient assessment—an important part of nursing documentation—is performed either at the time of admission or within a period preceding or following admission that is specified in the health care facility policy. The Joint Commission requires that the nursing assessment be completed within twenty-four hours of admission. The assessment includes consideration of biophysical, psychosocial, environmental, self-care, educational, and discharge planning factors.

When the patient is transferred to another nursing unit or is discharged from the health care facility, a nurse documents the patient’s present status in the health record. The record also reflects any discharge instructions provided to the patient or patient’s representative.

Usually, the health care facility’s established policy on nursing reports dictates the frequency and method of recording information. Forms to facilitate nursing documentation have check columns for routine services rendered. Nursing notes may be documented on nursing forms. Alternatively, a system of integrated progress notes may be used. In a system, all health care practitioners document patient care on a universal form (see Chapter Two).

Nursing care plans may be maintained separately from the patient health record at the nursing unit, and this information may or may not become a part of the health record. If the necessary information is recorded elsewhere in the record, the care plans may be retained temporary (as determined by health care facility policy) and then destroyed. If the information documented reflected in the care plan is not a recapitulation of information reflected in the record the care plan becomes a part of the patient’s permanent health record.

Therapy Reports. Therapy services are provided to the patient on physician order. Service provided must accordance with the written plan of treatment. The original reports of the evaluation, recommendations, progress, and outcome of therapy department personnel, such as physical, respiratory, occupational, or speech, are to be including in the patient’s health record.

Case Management or Social Service Report. Case management or social service reports often contain sensitive details of the patient’s personal life. Because some of this information might be of a hearsay nature that could be prejudicial to the patient or misinterpreted at a later date, the health care facility may prefer to have the social service department prepare an interpretative summary for the patient’s record. The summary contains only that information of value to the physician and other professionals contributing to the patient’s care. The sensitive information is retained in the social service department’s files.

Dietary services. Like other members of the health care team, the dietitian cooperates by implementing the written orders of the attending physician. Each patient’s
nutritional care is planned, and an interdisciplinary nutrition therapy plan is developed and periodically updated for patients who are at nutritional risk. The dietician is required to promptly record in the patient’s health record any pertinent, meaningful observations and information on the patient’s food habits, food acceptance, and nutritional care plan. Whether the traditional source-oriented record format or the problem-oriented format is used, the health record entries should be timely, well organized, definitive, and amenable to the evaluation of the nutritional needs of the patient. The Joint Commission standards specify documentation requirements for nutrition services.

Federal and State Requirements for Record content. In addition to the information-capture standards on record content that were described earlier, health care facilities must also adhere to federal and state requirements for health record content. As noted in some of the proceeding sections, health care facilities licensed to accept federal reimbursement must also meet the Medicare Conditions of Participation (COP) that are administered by the Center for Medicare and Medicaid Services (CMS). The fiscal intermediary in each state can provided copies of the federal legislation that affects the health information system.

Each state board or department of health may have specific regulations that pertain to health record documentation. State regulations are usually available from the state’s department of public health or other entity responsible for the licensure of health care facilities.

CONTEMPORARY TRENDS IN HEALTH RECORD ANALYSIS

The traditional, detailed review of the health record after discharge affords certain advantages. The chief advantage is that the HIM professional can perform a careful of the record as a whole. A disadvantage of the discharge analysis is that it can delay the completion or correction of documentation, which can then adversely affect patient care. One might question, for example, whether it is ethical to sign orders after a patient is discharge and how much a practice benefits the patient’s care. One might also wonder what effect such unsigned orders may have on the health care facility’s potential liability for a negative patient outcome. Clearly, retrospective documentation does not add value to patient care. In recognition of this fact, AHIMA has developed a position statement that supports the need for clinical information to be made available at the point of care for decision making. The recommendation is that health care practitioners record their findings at the point of care or within twenty-four hours of an encounter.

Another disadvantage of the traditional discharge analysis is that it can hinder the billing process because the coding and sequencing of diagnoses and procedures cannot be performed until the requisite documentation is entered in the record. When the HIM department has to wait for documentation to be completed in order to code data and submit the record to the business office, the financial impact on the health care facility is significant. To facilitate the billing process, many health care facilities require immediate completion of some parts of the record after discharge but are willing to modify completion requirements in other areas. In addition, many HIM departments have changed the traditional sequence of post discharge processing of the record from assembly, the analysis, and then coding to coding first, the assembly, and analysis. The sequence facilitates timely coding, and thus the bill can be submitted more promptly.
A final drawback of traditional discharge analysis is the amount of time that is required to perform tasks such as reviewing records for omissions, notifying physicians of needed information, counting delinquent records, and pursuing late documentation. From the HIM professional’s point of view, this time might be better spent managing, analyzing, and presenting health data, planning and implementing the computerization of records, and assessing and meeting customer needs. For all these reasons, the focus of contemporary health record practice has begun to shift from detailed discharge analysis to either or more simplified approach or concurrent analysis. In an attempt to operate more efficiently, some health care facilities have also sought to streamline the analysis process or adopt a more focused type of health record review.

Concurrent Analysis
In the concurrent approach to the health record review, the HIM professional performs quantitative analysis on the nursing units while the patient is still hospitalized. (Workspace for this type of analysis must be provided at or near the nursing station.) Reviews of the record are performed daily to identify deficiencies and to notify the staff members who are responsible for correcting them. The goal of concurrent analysis is to make the record as complete as while the patient is in the facility receiving care, so as to improve documentation and, ultimately, patient care. When concurrent approach is used, other record processing functions may be performed at the remote location as well. The record may be assembled in permanent filing order, completed, abstracted, coded, and assigned a DGR within a few hours of the patient’s discharge. Final record processing and permanent filling still take a place in the HIM department.

The Electronic Signature and Other Technique
Traditionally, HIM professionals have gone to great lengths during the analysis process to secure the physician’s signature on various reports in the health record. Signatures have been sought on dictated reports such as the H&P, operative report, and the clinical resume. The electronic signature, which has been approved by the Joint Commission and is acceptable under the Medicare Conditions of Participation, has eliminate much of the tagging and flagging associated with the health record in the past.

Electronic signatures incorporate the dictation system’s physician identifier code that is the key to his or her dictation of patient health record documents. In such a system, each individual who is authorized to use dictation system has an assigned security code. To gain access to the system, the physician must enter his or her unique identification code. To main security and meet Joint Commission standards, every physician participation form verifying that he or she is the only one who will use it.

The responsible health care practitioner signs the record entry by entering a unique code or password that verifies his or her identity. A statement may appear on the document, such as “electronically signed by Alex Smith, MD,” with the date and time noted. The Joint Commission requires that the computer system allow the author to review the document online before signing electronically. Therefore, before the electronic signatures is applied, the physician should have an opportunity to review a hard copy or an on-line version of the document and to revise the document, correct any errors, or enter any missing data.

Simplified Deficiency Processing
In addition to the electronic signature, other streamline techniques have eliminated the flagging of orders or progress notes with missing signatures after discharge. Health care facilities that follow one or more of these practices may nevertheless retain requirements in key areas, such as requiring authentication on the history and physical examinations, operative reports, consultations, and discharge summaries, as required by the Joint Commission.

With simplified deficiency processing, retrospective chart analysis still occurs but in a reduced form. Only those items identified as critical are analyzed for completeness. This method is effective only if all concerned parties are in agreement and if the medical staff is educated about the limits of retrospective review and their responsibilities regarding timely documentation and authentication. Continued monitoring of the critical deficiencies is important, with feedback provided to the medical staff departments and individual members.

Records may be marked “as is” and placed in the permanent file, even when there are deficiencies in the H&P, operative reports, or other pertinent dictated reports. For example, a time frame (such as forty-five days) could be established to provide the physician ample opportunity to complete the chart. If the record is not completed in the specified time frame, it is then filed “as is.”

The Focus Review

Another example of operational efficiency is the focused review. The traditional discharge analysis requires a review of each item or form in the record for its completeness after patient discharge. In the focused review, a sample of records is evaluated for the presence or absence of crucial elements, as determined by the department or service. These elements differ by their relative importance to the department or service. The key to the effectiveness of the focused review is feedback to committees and medical staff departments. Results of the focused reviews are tabulated, analyzed, and presented. The departments and committees are responsible for developing action plans to resolve the problems at the point of documentation rather than correct them after patient discharge. Concurrent analysis can be accomplished while the patient record is on the floor if specific problems are identified in the focused review.

AHIMA published a practice brief titled “Best Practices in Medical Record Documentation and Completion” to assist HIM professionals in making improvements in their facilities. The practice brief provides a table of best practices in the areas of documentation and chart completion. It would be available as long as it is deemed current at AHIMA web site at www.ahima.org.

In addition, AHIMA has challenged its members to work together to prevent incomplete health records instead of concentrating on delinquencies. AHIMA is continuing to work with the Joint Commission in the management of information standards. The challenge for the HIM professional is to devise methodologies that improve the documentation system as a whole—not just the individual record.

The HIM professional is responsible for helping the health care facility move away from detailed postdischarge analysis to a system that capture key health information concurrent with the patient stay. The health care provider is responsible for accurately and completely documenting the events of the patient’s stay, but the HIM professional bears the responsibility for assisting in the development and maintenance of a health information system that facilitates this documentation.
CONCLUSION health record analysis has been a key function of the HIM profession. Today, however, the focus of the HIM professional has shifted from treating delinquencies to preventing incomplete health records. A record that is complete and produced on a timely basis is not the responsibility of the HIM professional alone but of all who record information in it. Complete information is integral to improving the quality of care rendered at the institution, facilitating the billing process, and allowing the HIM professional to perform the crucial functions of managing, analyzing, and presenting health care data.