DELINQUENT MEDICAL RECORDS: WHO ARE THE STAKEHOLDERS FOR TIMELY MEDICAL DOCUMENTATION?

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Delinquent Medical Records: Who Are the Stakeholders for Timely Medical Documentation?

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Abstract

The explosion of electronic documentation associated with Meaningful Use-certified electronic health record systems has led to a massive increase in provider workload for completion and finalization of patient encounters. Delinquency of required documentation affects multiple areas of hospital operations. We present the major stakeholders affected by delinquency of the electronic medical record and examine the differing perspectives to gain insight for successful engagement to reduce the burden of medical record delinquency.

Keywords

Medical records; delinquency; timeliness; hospital; inpatient; health information management

Introduction

The management of hospital records involves different silos of stakeholders, each with differing perspectives of the importance of the medical record, including bias against financial operations by medical staff. Here we present these perspectives in order to gain insight in how to engage stakeholders, especially relating to the burden of medical record delinquency.

The significance and impact of the Centers for Medicare & Medicaid Services (CMS) Electronic Health Record (EHR) Incentive Programs on the practice of medical care in the United States qualifies as one of the most far-reaching technologically-based changes to practice in medical history. In 2012 US hospitals completed over 36 million admissions resulting in more than 164 million hospital days. In that year, the US hospital use of qualified EHR rose from 27-44 percent overall.[1] In February 2016, 95 percent of all eligible US hospitals had converted to Meaningful Use-certified EHR systems.[2] The implication is clear: nearly all inpatient records are electronic, so with the educated approximation that the average patient needs only 3 notes a day while in hospital, half a billion documents will need composition and processing for inpatient encounters alone. With the addition of emergency department and ambulatory visits, providers in the US will create and finalize billions of records every year.

The American Medical Association sponsored the 2013 RAND report, *Factors affecting physician professional satisfaction and their implications for patient care, health systems, and health policy*. In this report, physicians and practice managers found improved satisfaction with EHR in terms of better access to data and improvement in some aspects of patient care. In contrast, physician satisfaction with health IT was found to have "worsened satisfaction" in the areas of: time-consuming

data entry, user interface and workflow mismatch, interference with face-to-face patient care, information overload, threat to practice finances, the requirement for physicians to perform lower-skilled work, and template-based notes which degrade the quality of clinical documentation[3]. In their report titled *Crossing the Quality Chasm*, the Institute of Medicine defines quality to include timeliness ("care should continually reduce waiting times and delays for both patients and those that give care") and efficiency ("the reduction of the total cost of care should be never-ending.")[4,5] In the 2014 Next Accreditation System of the Accreditation Council for Graduate Medical Education, the role of professionalism for residents and fellows of teaching hospitals now requires "training on policies and procedures regarding appropriate documentation of clinical care in the clinical site's electronic health record" (see Professionalism, Pathway 1, Property 2).[6]

Given the promise of meaningful use, the reality of provider satisfaction, the implications for quality and the obligation for training of residents and fellows, we ask about the role of the delinquency of medical documentation. The impact of delinquency of the electronic medical record and the implications for the hospital stakeholders is largely unknown and unpublished. Here we present the major hospital stakeholders for delinquent documentation.

Finance

Each inpatient admission creates a story told by the medical record. The summarization of this story by coding specialists requires timely completion and required elements in order to construct an accurate representation. The comprehensive data elements estimate severity of illness, map and crosswalk the associated diagnoses to diagnosis related groups, contribute to a casemix index, and estimate mortality risk. Professional fees, facility fees, and hospital global charges are reliant on the both the accuracy and the timeliness of medical documentation. During the period of 2014 to 2016 the American Hospital Association monitored the CMS recovery audit program with hospital denials from 7-10% due to "no or insufficient documentation of the medical record."[7]

Delinquency of required documentation affects the ability to submit charges to payers due to filing time limits which vary by payer. For a hospital to maintain provider interim payment status (PIP) 85% of charges must be submitted within 30 days. Billing past the filing limit or submitting partial charges such as PIP both have the same result: hospitals are providing those services for free due to medical record delinquency. A given clinical service line is accountable for balancing revenue with expenses. Clinical service lines and their providers with delinquent or unbilled services negatively impact service line revenue and jeopardize staffing and other expenses.

Risk Management

The narrative of the patient's hospitalization as told by the medical record has an exposition recounted within the admission history and physical (H&P), action described during hospital stay, and a denouement captured by the discharge summary. As with story, gaps or deficiencies in the

telling introduce doubts and frustrations, but with far more tangible consequences. A missing or delinquent H&P calls into question what the clinical team knew, when they knew it, and whether a condition or finding was present on admission. Procedural documents, particularly the operative notes, lose accuracy with hindsight. Incomplete and delinquent records make the defense position in legal proceedings untenable. Part of the healthcare journey for high reliability includes identifying risks and developing risk mitigation strategies, and risk management associated with the delinquent medical record is a vital process of this journey.

Medical Staff

Accredited hospitals have mechanisms for credentialing and monitoring medical staff defined by the Joint Commission such as ongoing provider practice evaluation, OPPE (Joint Commission Medical Standard MS.08.01.03). The monitoring of hospital staff may include a variety of global metrics such as mortality, length of stay, infection, and blood utilization. Without other recourse to effectively set direct consequences for poor EHR performance, Health Information Management (HIM) leadership may need to partner with Medical Staff leadership to set metrics and standards associated with documentation. These may include: unsigned verbal orders, delinquent operative notes, delinquent discharge summaries, and delinquent documentation for ambulatory encounters. As a means of enforcement, several hospital systems have instituted a suspension mechanism whereby providers voluntarily relinquish their privileges when they exceed a threshold metric for the number of delinquent documents. This voluntarily relinquishment is not reportable to state medical boards but still can be an effective mechanism for medical staff out of compliance with global metrics. Hospitals must devote significant administrative effort to the process of suspending and re-instating the privileges, all of which necessarily results in a total, non-recoverable waste of staff effort. HIM leadership bears the accountability and cost of this non-value-added work.

Patient Safety and Quality of Care Coordination

Hospital consumers include patients, families, and also referring providers. Absent and delinquent documentation from hospital admissions does a disservice to referring providers tasked with the transition of care from the hospital to the ambulatory setting. This can prove inherently unsafe for the patient and leads to waste of time and resources spent identifying interventions and avoiding duplication care. Discharge failure due to delinquent documentation has a direct role in pay-for-performance mechanisms such as 30-day readmission rates. Safe, effective care coordination relies entirely on accurate and timely medical documentation. Chronic failure due to delinquency of medical documentation will affect the decision making of all consumers of hospital services.

Conclusion

Health care organizations with HIM and medical staff leadership that implement effective accountability models for improving timely completion of medical documentation has a tremendous potential impact on delinquency of medical records. Finance stands to gain as billings holds are

reduced, casemix designations increase in accuracy, and identification of diagnoses present on admission helps to clarify quality metrics for reimbursement. Risk is mitigated with timely and accurate documentation, particularly with production of the medical record. Medical staff credentialing processes that include compliance with documentation standards greatly reduce wasted effort and resources. Both patient safety and quality of care improve as the major stakeholders in medical care, patients and their families, have optimal and timely coordination of their care. Future efforts in accountability models will help delineate the most meaningful metrics of the delinquent record in order to provide management and leadership with effective interventions.

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