

1/31/05

Data Quality and the Medical Record Committee in the Electronic World

Leslie Ann Fox, MA, RHIA, Patty Thierry Sheridan, MBA, RHIA, CCS

Thank you to Advance Magazine for permission to use this article

Leslie: Last year we interviewed several HIM directors to hear about their involvement in the electronic health record (EHR) transition. This year we want to talk more about the impact of the EHR transition on HIM roles and responsibilities.

Patty: The role of HIM departments in assuring data quality is going to be a prime area for process redesign. I want to know how HIM professionals are dealing with data quality issues in the electronic practice environment. Also, what happens to the traditional role working closely with a medical record committee (MRC) of the medical staff on data quality issues? The transition to e-HIM™ will require HIM professionals to help redefine the MRC's roles and responsibilities in the EHR world.

Leslie: Leading the MRC through their evolution is indeed part of the transition process. I spoke again this year with Julie Bryant, RHIA, director of information services and medical record services at Northwestern Memorial Hospital in Chicago to follow-up on their progress toward EHR and e-HIM. We talked about data quality processes, as well as the evolution of their MRC. Let me share with you some of our conversation.

Patty: Julie was a great example of HIM involvement in our Hands-on Help column, "When HIM Has a Seat at the EHR Table" (March 1, 2004). Yes, please bring us up to date on what they are doing about data quality and the role of the MRC.

Leslie: Julie, I know that your medicine department's records are more than 95 percent electronic now, and the rest of your departments will be close to that by the end of this year. Now that you are so far along with the EHR, what are your next steps for the HIM department?

Julie: Our goal this year is to define the e-HIM vision and further the transformation of our medical record department to an e-HIM department. Currently I am in the midst of strategic planning with our HIM management team. We want to determine by midyear how we will change workflows and reallocate resources in a totally electronic world.

Our fiscal year begins in September, so I want to have a budget for "the new e-HIM department" even if we aren't quite all the way there. We can make adjustments if necessary, but I want us to be very focused on creating the e-HIM functions and processes that will make us successful in the future.

Leslie: Do you know the focus of the e-HIM transformation yet?

Julie: Data quality analysis will be a big part of our role. As we implemented components of the EHR, new HIM tasks kept emerging for which we had to create processes on the fly. Now I want to develop definitive guidelines for addressing the documentation quality issues that arise with EHRs.

Leslie: Can you give me some examples?

Julie: Sure. Our EHR system has an administrative in-box for managing exceptions. If an attending physician refuses to co-sign a resident's order or a verbal order, the unsigned order gets routed to the administrative in-box for the disposition. An HIM technician needs to investigate the order and determine what happened: is it an order entry error; is the order attached to the wrong record; did the patient receive a wrong medication or test? We need to develop guidelines that define how the HIM technician should disposition these occurrences.

And this is just one example of the type of problems that are routed to the administrative in-box daily.

Leslie: What other new tasks are emerging for HIM technicians in managing EHRs?

Julie: It is critical that we have a good process for person identification management. We need to make sure that data is getting to the right person's record. For example, HIM record processing technicians will be responsible for electronic filing of documents that are faxed to the hospital. The faxed documents will go into a queue on the EHR system and an HIM technician will drag and drop the document into the patient's record. Eventually we will have electronic posting in which prenatal, or other documents, will be faxed directly from the physician's office to the EHR. The patient's identification information will be automatically matched through an electronic posting program so the document will be attached to the right record. However, errors may occur and we will need to clean them up.

We need a process to assure that mismatches are routed expeditiously to a data quality technician's queue for disposition.

Leslie: It sounds like much of what you are working on at the present is around data quality. Will your new processes impact the role of the MRC? Are there other ways in which the EHR is impacting the MRC?

Julie: We have already started to evaluate the role of the MRC and have taken some initial steps. We started by defining our needs. First, we need an oversight body for the EHR content. We want a group that will define the process for introducing changes into the EHR, a role similar to that of the old forms committee.

Second, we plan to implement clinical decision support in the EHR, i.e., alerts and warnings. If red flags pop up too often, people will ignore them. To have the best impact on patient care, a group must decide what alerts make the most sense to turn on first, second, etc.

Third, we need to monitor system-wide metrics for the electronic environment. For example, the Leapfrog Group's standards call for 75 percent of physician orders to be entered by the physicians into a system that has prescribing error prevention software. One way to make it easier for physicians to do order entry is to create evidence-based order sets. One role for the oversight group will be to monitor order sets: how many order sets are in use, are they evidence-based, are they being used? Operationally, it will be the HIM staff's job to monitor the use of order sets and to refer issues of non-compliance to the appropriate department or quality assurance (QA) committee, informing the oversight group as well.

Leslie: Where are you in the process of transforming the forms committee and the medical record committee?

Julie: We have disbanded the forms committee, and we are creating a Clinical Informatics Council (CIC), which we think may also become the MRC of the future. The CIC is meeting every other week initially. The MRC meets every other month. I will evaluate how the CIC relates to the MRC, and eventually we will determine

whether or not the CIC actually replaces the MRC.

Leslie: Can you tell me more about the CIC?

Julie: We had our first meeting just this past November and are still in the process of education, for example learning what is in everyone's workflows. Its members include physicians, information services, nursing, medical records, pharmacy, quality/patient safety and others as required.

Leslie: What is the group's mandate?

Julie: The stated goal is for the CIC to define and establish the committee who will optimize the use of technology to enable the delivery of safe and effective patient care. The focus will be on the management of technology around the priority of safe and effective patient care. The group will have three functions: 1) Standardize EHR content, 2) Prioritize clinical decision support, and 3) Measure and monitor the EHR.

Leslie: Can you elaborate a little more on each of the functions?

Julie: To standardize the EHR, we envision the CIC working with the clinical quality committees to standardize the content of documentation and order sets to support evidence-based practice. A priority will be to make sure that we build content to meet national and regulatory standards as they evolve over time.

For the clinical decision support function, the CIC will define a methodology for selecting and prioritizing the design, build and deployment of rules and alerts. It will prioritize intelligence needs around rules and alerts using standardized criteria.

For measuring and monitoring the EHR, the CIC plans to choose measures to demonstrate the benefits of EHRs, monitor the deployment of evidence-based care via order set utilization and monitor the effectiveness of rules and alerts.

Leslie: Where will the CIC fit into your organizational structure?

Julie: The CIC will report to the Medical Staff Quality Management Committee along with many other interdisciplinary clinical quality groups. The Medical Staff Quality Management Committee reports to the Medical Executive Committee, which reports to the Professional Standards Committee of the hospital's Board of Directors. As a clinical quality committee, the CIC will have the appropriate privilege and protections of the Illinois Medical Studies Act.

Leslie: What was the most important lesson learned in the past year of your transition to EHRs?

Julie: Our most important lesson this year was learned when we had an unexpected downtime event. A system outage is the equivalent of a disaster. We did a post-event debriefing with users to understand how our caregivers coped, and how well our emergency procedures work. I stressed the importance of learning the effects on patient care. We must assure we practice our disaster procedures, and that we learn from the drills how to avoid all harm to patients.

The outage led to my taking on yet another new HIM role, incident commander.

Leslie: Julie, I want to thank you for again taking the time to share with our readers the exciting work you are doing to lead the transition to EHR and the transformation of HIM at your hospital.

Leslie Ann Fox is chief executive officer and Patty Thierry Sheridan is president of Care Communications Inc., a national HIM consulting and staffing company headquartered in Chicago. They invite readers to send their thoughts and opinions on this column to lfox@care-communications.com or pthierry@care-communications.com.