

Meeting Meaningful Use Criteria: An HIM Vision or Nightmare? Part 2

June, 2011

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LESLIE: Last month we began exploring the role of HIM professionals in helping their healthcare organizations meet the Centers for Medicare & Medicaid Services (CMS) meaningful use (MU) criteria in Part 1. We talked with Brenda S. Olson, MEd, CHP, RHIA, vice president for health information management at Great Plains Health Alliance, which is headquartered in Phillipsburg, KS. As the corporate HIM resource for 29 small and rural critical access facilities, Brenda works with the HIM professionals in her facilities to provide leadership, communication and education for the application of the MU criteria to their EHR system.

PATTY: Brenda helped us to understand that the value of HIM input is even more important in light of the MU criteria, enabling HIM professionals to have more influence on the design of their EHR as it evolves over time. In this column, we want to explore in more detail the ways in which MU criteria is helping improve existing EHRs.

LESLIE: Brenda, please give us an example of how MU impacts the EHR in your healthcare facilities?

BRENDA: A simple example is that data on advanced directives has been requested upon admission for many years; however, that fact wasn't always documented until the MU criteria forced the issue. Now that it is a requirement of MU, we can make it mandatory for completing the registration.

PATTY: I have heard that correcting entries in an EHR can be a problem. Has it been an issue for you?

BRENDA: It absolutely has been an issue. As you know, for legal purposes corrections were made in paper records by drawing a single line through the voided entry, writing error and dating and initialing the change. This is of course critical to maintaining the legal integrity of the patient health record. However, when a clinician voids an entry in the EHR we are using and we print the document, the printed version only indicates "voided" -- it does not show the original documentation. We currently have to do screen prints on those entries to respond to a request for a legal medical record to show what the 'voided' entry contained.

LESLIE: I am sure it is frustrating for your HIM team when such basic HIM processes cannot be completed efficiently.

BRENDA: Yes, it is. The HIM voice needs to be heard earlier in the EHR design and implementation process. We must have greater involvement of HIM professionals on the vendor product development teams, and on the EHR steering committees that oversee the implementation and design in the healthcare facilities. The MU criteria are helping to reveal the backend documentation issues that have not been addressed in today's EHR products.

LESLIE: I think some EHRs are still in their infancy. They will mature as vendors and customers collaborate to identify and address these important documentation requirements.

PATTY: Yes and the need to improve EHRs is more than just to meet legal record and meaningful use requirements. There are serious challenges in meeting the needs of care-givers, quality management reviewers, researchers and administrative personnel just to name a few.

BRENDA: Here is another example. The MU criteria states you need to provide a discharge summary, however the summaries generated by the EHR are based mostly on nursing documentation. They are not traditional discharge summaries, documents created by a physician at the end of a patient's stay. The summary of care document printed from the EHR provides vital signs, medications, allergies, labs and some radiology but not the clinical information recorded or dictated by physicians in the history and physical, the consultation reports, report of operation, progress notes or the final clinical discharge summary.

LESLIE: I hear you. After a brief hospital stay during a recent vacation trip, I was given a "summary" printed from the EHR by the discharge nurse. However to get the information my doctor at home needed, the physician who cared for me provided a number of different documents that he printed from his record at his office. The hospital had a well-known, widely used EHR, but I felt like I was living in the dark ages of fragmented medical records.

BRENDA: The MU criteria have helped us to improve nursing documentation from stories to hard data, but physician documentation isn't where we need it to be yet.

PATTY: When a discharge summary is completed by a physician, it seems like patients for now will receive a scanned document until discrete physician documentation is available within the EHR.

BRENDA. Yes, patients will receive a scanned document for now. Another challenge we have is that the problem list is a requirement for a certified EHR. We thought meeting this requirement would be easy, but it is hard. We don't know where the problems on the list should come from -- Nursing documentation? Physician documentation? A combination of both? And should the problem list be reflective of one encounter? The entire life of the patient?

PATTY: The clock is ticking and it is going to take time for the EHR documentation to improve enough to fully meet the MU criteria in most institutions.

BRENDA: The incentives will be there only until 2016, and then the penalties will kick in. It will be especially hard on those institutions that decide to just take the penalties, especially the rural healthcare facilities.

PATTY: Brenda, what are your most important lessons learned from working with your facilities on EHRs and MU?

BRENDA: Here are 4 important lessons

Team work is critical and everyone needs to be a full member of the team moving toward the same goals. Everyone needs to understand that you cannot change from paper to electronic records without changing the work processes of users.

Most of the clinical products I have seen do not allow for mandatory fields, thus you have to have budget for staff to monitor and correct the critical data fields.

The HIM professional must be on the clinical documentation committee/team. They have an important leadership role -- creating urgency, educating and communicating the important information as often as necessary until it can be internalized by all. They are also the voice that educates the EHR team on how the record is utilized

after a patient leaves a facility. MU brings to the forefront that clinical information not only viewed and needed concurrently but also retrospectively.

LESLIE: Thank you, Brenda, for sharing your passion for high quality electronic health record documentation. In many ways, that is the untold story of EHRs in 2011 and bravo to you for sharing your thinking on this issue.

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