Health Information Management

Revised Edition

Principles and Organization for Health Record Services

Margaret A. Skurka

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PREFACE

Health Information Management: Principles and Organization for Health Record Services, Revised Edition, recognizes the continuing need for guidance in developing efficient health information management systems for health care institutions. This important revision of the 1994 *Health Information Management in Hospitals: Principles and Organization for Health Record Services* is designed to capture the significant changes in the health information management field and profession in recent years. (The first edition of this book, published in 1984, replaced *Medical Record Departments in Hospitals: Guide to Organization*, which was originally published by the American Hospital Association in 1962 and revised in 1972. A second edition of this book was published in 1988 under the title *Organization of Medical Record Departments in Hospitals*.)

The book serves as a comprehensive general reference to patient record and health information management. It is useful to a health care institution's chief executive, chief operating and chief financial officers, and information system personnel. It is also essential reading for allied health professionals who need a general overview and understanding of health information management practices. The author covers appropriate information for instructors and students in health information management educational programs, and serves as an introduction to HIM practices and issues for other health-related and hospital information systems education programs. In addition, individuals in smaller health care institutions will find this book useful in applying the basic principles of health information management. Because the appropriate application of these basic principles requires a careful analysis of the individual health care institution's needs, various methods of health information management—and some advantages and disadvantages of each—will be discussed herein.

The health care industry has undergone extraordinary change, and more advances are expected as we move toward the new millennium. Technology is rapidly changing how we manage health care information. The health information managers of the future will manage data, oversee document and repository systems, coordinate patient information,

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secure all electronically maintained information, supply senior management with information for decision making and strategy development, ensure data quality, and direct enterprise- or facilitywide health information management. The profession is in a significant period of change and the health information management professional is changing to meet the information management requirements of the future.

Throughout this book, the term health information management (HIM) professional will be used to encompass both the registered record administrator (RRA) and the accredited record technician (ART), because professionals at both levels hold a variety of positions within the profession. Specific references are made to the department director as a health information manager who may be an RRA or an ART. Beause *health record* and *health information management* have almost completely replaced *medical record* and *medical record management,* only the current terminology will be used in this book.

The American Health Information Management Association comprises more than 37,000 members. In addition to the credentials of RRA and ART, the organization sponsors examinations leading to the credential of certified coding specialist (CCS) and certified coding specialist, physician based (CCS-P). Other organizations offer certification in the areas of tumor registry, medical transcription, and quality management. Together, all these individuals provide the expertise necessary to develop and maintain the health information system necessary for the next millennium.

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A special thanks also to my family—husband Richard and children Erik, Kirstin, and Erin—who again, during my fourth revision of this book, showed significant patience and understanding when many an evening (as well as part of a family vacation) was spent at the computer. They've always understood and accepted my intensity and commitment with regard to this profession, and for that I am grateful. The book is dedicated to them and to my very wonderful parents, Edward and Ella Flettre Galvanek. My parents have always provided me with the mental support and a positive attitude approach to life that makes so many things possible.

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1 Health Information Management and the Health Care Institution

The terms *medical record* and *health record* are sometimes used interchangeably in referring to the document that captures the health information of a particular patient. However, a distinction should be made between the two types of records. *Medical record* implies that physicians participate in and supervise the medical care provided to patients in health care institutions. *Health record* is a term that encompasses not only the record of medical care provided but also a listing of services provided by nonphysician health care practitioners. This accounting may include records of an individual's health status that is kept on file with an agency, third-party payer, non–health care institution, or even by the patient. Such health records may be used in health benefits administration, applications for insurance coverage, research studies, employment records, and in social service plans for individual or family care.

The health record is a valuable tool in providing high-quality patient care, preventing disease, and promoting health. Health records assist the preparation of health service statistics used to evaluate the efficiency and effectiveness of care and to substantiate the provision of patient care services and treatment. The health record supports medical education, health services, and clinical research, and it provides documentation for reimbursement of expenditures for health care services and for analysis of alternative methods of coverage. It is also used in developing public policy on health care, including regulation, legislation, accreditation, and health care reform.

To be accredited by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), a hospital must demonstrate substantial overall compliance with the commission's standards for hospital operations. Included in these requirements are standards for the maintenance and adequacy of health records. Directly or indirectly, the board of trustees, the CEO, the medical staff, and the health information management (HIM) professional all share responsibility to meet Joint Commission and other standards, regulations, and policies regarding the health record. This chapter provides an overview of each group's role in the creation, maintenance, and protection of health records that are accurate, timely, and complete. (See figure 1-1.)

FIGURE 1-1. Responsibility for Medical Records

Board

- Corporate plans
- Maintain quality care
- Establish policy making, planning, administrative mechanisms
- Appoint CEO

CEO

- Implement system for maintaining medical records
- Provide direction, staffing, and facilities for HIM department
- Enforce record regulations, policies, and standards
- Protect records and their contents

Medical Staff

- Review record rules, regulations, policies, and standards
- Participate in decisions regarding format of record and forms
- Specify medical staff membership qualifications
- Delineate clinical privileges qualifications
- Authenticate medical record entries

HIM Department

- Maintain record and information storage and retrieval system
- Preserve record confidentiality, data security, integrity, and access
- Perform coding, classification, and all related functions
- Manage all paper and paperless patient information
- Organize, produce, and disseminate health information

HIM Professional

- Coordinate data collection
- Monitor information integrity
- Assure record access to qualified individuals
- Organize, analyze, and evaluate health information
- Consult on information management for other departments
- Compile administrative and health statistics
- Code diagnoses, therapies, and other procedures
- Input and retrieve computerized health data

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THE RESPONSIBILITY OF THE BOARD AND CEO FOR HEALTH RECORDS

An institution's governing body, or board of trustees, typically comprises individuals who are recognized leaders in their field and have a responsible standing in the community. Trustees may be appointed or elected by the existing board or by the corporate office to serve for a specific term.

The board of trustees is responsible for establishing policy, maintaining high-quality patient care, and providing institutional management and planning for the health care institution. The board is also responsible for corporate planning to meet the needs of the community that is served by the institution. To fulfill its responsibilities, the board establishes mechanisms for performing necessary policy making, planning, and administrative functions, including functions related to health records. These mechanisms include appointment of a CEO, support for the medical staff as an effective self-governing body, and creation of appropriate committees.

The board of trustees holds the CEO responsible for implementing established policies for the operation of the institution and for keeping the governing body well informed about day-to-day operations. The CEO is also responsible for informing the governing body of federal, state, and local events that may affect hospital operations and planning.

The board of trustees holds the medical staff responsible for the development, adoption, and periodic review of medical staff bylaws and rules and regulations that are consistent with hospital policy. The medical staff, as well as the staffs of various departments and services, is also required to implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care. The purpose of monitoring and evaluating is twofold: to identify opportunities for improving patient care and to identify and resolve patient care problems.

Optimal operation of a health care institution requires the combined efforts of the medical staff, the CEO, and the governing body. This is typically accomplished through the establishment of a joint committee to address activities and problems of mutual concern.

Ownership, Maintenance, and Protection of the Record

The CEO's specific responsibility for the health record relates to ownership and services. The actual health record is regarded as the property of the health care institution and is maintained for the benefit of the patient, the medical staff, and the institution. The CEO is responsible to the governing body for implementing a system for maintaining adequate medical records on each individual who is evaluated or treated as an inpatient, ambulatory care patient, or emergency patient. The CEO is also responsible for safeguarding the record and its contents against loss, defacement, and tampering or use by unauthorized individuals.

The CEO and the Health Information Management Department

In addition to maintaining systems, the CEO also is accountable for the administrative functions of the institution and for delegating duties and responsibilities to subordinates. This management function includes providing the health information management (HIM) department with adequate direction, staffing, and facilities to perform all required functions. To fully utilize the talents of this department's director and staff, the CEO should be familiar with the individuals' skills and competencies. Health information management professionals should, in turn, seek opportunities to educate their superiors and peers about the skills needed by those in the HIM profession.

Because of the CEO's ultimately responsibility regarding the health record and its contents, he or she should support the HIM professionals in the enforcement of relevant laws, regulations, rules, and accreditation standards. When the HIM professional encounters difficulty with enforcement, the CEO should be prepared to intervene. Without such support, the director of the HIM department cannot provide high-quality services or meet optimum productivity standards.

THE RESPONSIBILITY OF THE MEDICAL STAFF FOR HEALTH RECORDS

A hospital's bylaws, rules, and regulations dictate each individual medical staff member's responsibility for maintaining timely, accurate, and complete health records. The institution's CEO and its organized medical staff share the responsibility for ensuring that hospital health records are complete, in accordance with the bylaws and rules and regulations for self-government approved by the hospital's board of trustees. Health record rules and regulations apply to the entire medical staff and should therefore be uniformly enforced.

In addition to adhering to rules and regulations regarding the health record, medical staff should actively participate in decisions regarding the format of the completed medical record, the design of record forms, and the medium on which records are preserved (hard copy, microfilm, optical disk, or computer storage).

Rule Compliance Review and Monitoring

As a part of the health care institution's performance-improvement activities, the medical staff is responsible for the regular review of all rules,

regulations, and policies related to medical record requirements. All records must be reviewed for clinical pertinence on a regular basis. A clinical pertinence documentation review consists of evaluating the completeness, adequacy, appropriateness, accuracy, and quality of documentation (as opposed to quality of care).

The objective of a review process is to ensure that each health record includes sufficient documentation of the patients' condition, progress, and outcome of care; documentation for the administration of tests and therapy as ordered; and documentation for notification and acceptance in any transfer of patient responsibility from one physician to another. The review process also should consider the adequacy of the health record for institutionwide quality, utilization, and risk management activities.

In hospitals with a small, nondepartmentalized medical staff, review may be carried out by the medical staff as a whole. In larger hospitals with organized clinical services, review may be performed by a committee or by members of individual departments. The standards of the Joint Commission imply that a quality improvement process is in place in all departments and that department directors are responsible for the continuous assessment of care and services provided. Therefore, representatives of the HIM department, the nursing services staff, and any other professionals who are directly involved in health record documentation also should take part in the record review process.

Clinical Privileges and Credentialing

In keeping with Joint Commission standards on the management of information services as described in the *Accreditation Manual for Hospitals*, the medical staff is responsible for specifying its membership categories and delineating qualifications for the granting of clinical privileges. The Joint Commission defines clinical privileges as "authorization granted to a practitioner to provide specific patient care services in the hospital within well-defined limits, based on the following factors, as applicable: license, education, training, experience, competence, health status, and judgment."[1] Physicians or dentists wishing to obtain privileges for a specific institution must apply for medical staff membership and/or clinical privileges. The granting of membership and privileges makes the affected individual responsible for adhering to the medical staff's existing rules and regulations for medical records. The exercise of clinical privileges within any department—if there are medical staff clinical departments—is subject to its rules and regulations and to the authority of the department chairman. Although the medical staff bears overall responsibility for the quality of professional services provided by those who are granted clinical privileges, the final accountability lies with the governing body.

Privileging of Dentists and Oral-Maxillofacial Surgeons The clinical privileges accorded to dentists and qualified oral-maxillofacial surgeons should delineate their responsibility for documenting procedures and diagnoses; writing orders; prescribing medications; and securing a physician's documentation of the patient's medical history, physical examination, and medical problems. Qualified oral-maxillofacial surgeons who admit patients with medical problems may perform the medical history and physical examination on those patients when the surgeons possess such privileges and may assess the medical risks of the proposed surgical and/or other invasive procedures. Dentists are typically responsible for the part of their patients' histories and physical examinations that relates to dentistry.

Privileging of Podiatrists Clinical privileges that are granted to podiatrists include delineation of the scope and extent of surgical procedures that they may perform, their authority to issue orders and prescribe medications, and other requirements such as shared responsibility for patient care with a physician member of the medical staff. Podiatrists are responsible for the part of their patients' histories and physical examinations that relates to podiatry. The attending physician is responsible for documenting the basic medical assessment of the patient and any medical problems.

Privileging of Nonphysician Caregivers Clinical privileges granted to nonphysician health care professionals or caregivers (such as psychologists and nurse practitioners) must delineate their responsibility for health record documentation and any requirements for documentation and counterauthentication by a physician staff member. When nonphysician members of the medical staff are granted privileges to admit patients for inpatient services, provisions should be made for prompt medical evaluation of their patients by qualified physicians. When care is provided by licensed independent practitioners (individuals permitted by law and by the institution to provide patient care services without direction or supervision), physicians must confirm their findings prior to major interventions. Licensed independent practitioners must operate within the scope of their accreditation and in a manner consistent with individually granted clinical privileges.

Credentialing is the process of assessing and validating the qualifications of a licensed independent practitioner to provide patient-care services. When members of the medical staff are considered for appointment or reappointment, one of the items considered is their performance in maintaining timely, accurate, and complete medical records. The determination is also based on an evaluation of the applicant's current training, experience, competence, and ability to perform the requested privileges. The responsibilities of the department chairperson—as specified in the medical staff bylaws and rules and regulations—include accountability for

all professional and administrative activities within the department, including the credentialing review process.

Authentication of Medical Record Entries

To ensure that entries in the medical record are authentic, all entries should be dated and signed by the author. Entries by house staff members, such as interns and residents, or by nonphysicians that require a countersignature by supervisory or attending medical staff members, should be defined in the medical staff rules and regulations. When members of the house staff are involved in patient care, sufficient evidence must be documented in the medical record to substantiate the active participation in, and supervision of, the patient's care by the attending physician who is responsible for the patient. The Joint Commission requires that those parts of the medical record that are the responsibility of the medical practitioner be authenticated by the practitioner. The Joint Commission defines authentication as a written signature or initials, a rubber-stamp signature, or an electronic signature. The use of electronic signatures is acceptable to the Joint Commission. (See chapter 2.)

When rubber-stamp signatures are authorized for use in authenticating entries in the patient record, their use must be controlled. The individual whose signature is replicated on a stamp should place a signed statement on file in the administrative offices of the hospital to the effect that he or she is the only one who has the stamp and is the only one who will use it. This precludes the delegation of usage for such a stamp to another individual.

In 1996, the Joint Commission changed its requirements for authentication of some entries in the medical record. The commission no longer requires physician signatures on verbal orders and certain other record entries. Medication orders in behavioral health care still require signatures. Other agencies or state laws may still require signatures; therefore, the HIM professional must be familiar with all regulations and guidelines. For more detailed information, see the American Health Information Management Association (AHIMA) practice brief titled "Authentication of Medical Record Entries"[2] in Appendix B of this book. (Other practice briefs are available to members of the AHIMA through the *Journal of AHIMA* or via the association's fax-back service.)

THE FUNCTIONS OF THE HEALTH INFORMATION MANAGEMENT DEPARTMENT

The HIM department has traditionally supported the health care institution's optimal standards for quality of care and services. Its functions may support the current and continuing care of the patient; the institution's

administrative processes; patient billing and accounting processes; medical education programs; health services research; utilization, risk, and quality management programs; legal and quasi-legal requirements; and extraneous patient services.

Common Departmental Responsibilities

The department's functions and specific demands for its services vary according to the type of institution. Common functions include the maintenance of a health record and information system in one or more forms. These provide storage and ready retrieval of clinical information by patient name or number, physician name or number, diagnosis, procedure, and other subject items deemed necessary. Maintenance of effective health records is essential because clinical decisions can directly depend on the completeness and accuracy of the record. A documentation error in listing medication to be administered to a patient could, for example, lead to a life-threatening situation.

A key departmental function involves coding, whereby diagnoses and narrative procedure language are converted into a recognized numerical system. Payment by various carriers is determined by scanning the coded data. Because coding provides the institution's business office with appropriate data for billing, it can have a measurable impact on finances. For example, an error in coding could result in a significant financial loss to the institution. The provision of high-quality coded data is also at the heart of efforts toward continuous quality improvement (CQI) in health care. High-quality coding can result in more effective disease prevention and patient care, more appropriate and timely reimbursement, and better planning and research decisions.

Health records can be stored as hard copy and/or in miniaturized (microfilm) or computerized form. HIM departments may deal with the computerized medical record—also called the paperless record, the computer-based patient record, the automated medical record, or the electronic medical record. In this type of record, all financial, administrative, and clinical information that pertains to patient care is entered into the computer at the time the service is provided. Regardless of the medium used to store the record, preserving the confidentiality of its information is crucial. The department manager must maintain the security of all electronically stored information, including the development and promotion of security requirements and policy and privilege delineation for access.

The Shift from Record Management to Information System Management

Efforts to shift their department's focus from the patient record to the HIM system has been the driving force of the HIM professional during the

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