Patient Chart Audit Guide

Uncovering Issues in Ambulatory Health Information Management

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INTRODUCTION

Why You're Here

Congratulations on taking the first step towards a better chart. As the old adage goes, the first step in optimizing your HIM processes is admitting you have a problem.... or something like that. But how do you know if you have a problem? It's hard to admit to issues if you're not sure they exist in the first place. This guide helps you do just that. This guide explores 5 chart management workflow processes where problems often occur:

1. **Daily Chart Indexing and Filing**
2. **Open Orders**
3. **Duplicate Documents**
4. **Paper Workflows**
5. **Legacy Information**

What's In This Guide

As you work through the guide, we'll provide you questions to ask your staff and simple audits you can perform to uncover issues you may not be aware of.
If you have a specific process you'd like to focus on, click on one of the links above and jump right to the corresponding section. When it's all said and done, you'll be ready for the road to recovery!

1 DAILY CHART INDEXING AND FILING

Problems You'll Encounter

The most common issue plaguing daily chart indexing and filing is document misfiles. Whether these documents are filed to an incorrect patient, document type, or sent to the wrong provider, accuracy is usually the culprit. Inconsistent filing procedures between staff or clinics can also cause problems. Beyond that, the time it takes from document receipt to accessibility in the EHR in another major pain point worth investigating. Listen to feedback from your providers. We all know if things are getting misfiled or worse, not filed at all, your providers will be there to let you know about it.

Why These Problems Occur

Each day your physicians and clinics generate and receive large volumes of paper and electronic information that must get filed into your EHR. Documents are typically filed by patient, document type, date of service, and potentially tasked to a provider for review, all using what is called hand-keying or inputting the information manually using people. Unfortunately, it's a fact that hand-keying is typically less than 99% accurate, leading to problems with at least 1% or more of your documents.

AUDITING TIPS

AUDITING YOUR DAILY FILING

- *Perform a simple audit. Do a random search of at least ten patients and browse their documents filed in your EHR. Pay attention to the document type, date of service, and other indexing information – is it correct? You may need to enact the help of an HIM team member for this. From here you can determine your accuracy rate.*
- *Review your HIM team's filing rules. Are they documented? Does each team member/clinic have the same set of rules? When was the last time the rules were updated?*
- *What's the internal policy on how long it should take to index and file documents in your EHR?*

2 OPEN ORDERS

Problems You'll Encounter

Keeping up with the volume of open orders can be daunting, and the process of closing them is incredibly tedious. It's not uncommon for a large organization's open referral and lab orders to number into the hundreds of thousands. Not to mention, many organizations are required to track and report on their order management.

Why These Problems Occur

When a physician sends a patient out for a lab test, specialist visit or procedure, someone on staff likely opens an order within your EHR. Until the lab test, consult or procedure is complete and documentation is received back and properly filed in EHR, the order remains open. **Open orders cause reporting issues, so beware.**

AUDITING TIPS

AUDITING YOUR ORDERS

- ***Determine the size of your problem. You may have to ask for help from a database or EHR analyst, but a report can instantly tell you how many open referral and lab orders your organization has. You may want to sit down for this one.***
- ***Ask your HIM team for feedback. Chances are they're the ones performing this process each day, so who better to gather information from.***
- ***Determine hours needed to fix the problem. Ask someone to show you the process of closing an order from start to finish. Note the amount of time and clicks it takes to complete an order. Now multiply the time it takes to complete one order by the total number of open orders you obtained on your report in #1 – shocking, huh?***

3 DUPLICATE DOCUMENTS

Problems You'll Encounter

If duplicate documents are an issue, expect it to impact three places within your organization—your physicians, HIM, and IT. If you use any sort of tasking, your providers are likely seeing the duplicate documents show up in their queues over and over—how annoying. When a provider complains about a duplicate document, guess who probably hears about it? That's right, HIM. And they must take the time to investigate these issues one by one. For your IT team, database management is a key responsibility, and duplicate documents can grow the size of the database exponentially.

Why These Problems Occur

Many times, outside organizations send you the same patient document multiple times. These are hard to catch and even harder to regulate.

AUDITING TIPS

AUDITING YOUR DUPLICATE DOCUMENTS

- ***Gather feedback from your physicians. We all know they love to talk, so let them! Best question to ask – are they seeing duplicate documents sent to them for tasking? If the answer is yes, dig deeper into their process. Ask them how they handle duplicate document situations?***
- ***Talk to your HIM team. They will know if this is a problem or not. Is there a policy and procedure in place for handling duplicate documents? If so, ask what it is and have them show you how they handle a duplicate document situation. Like order management, it's probably a bit tedious.***

4 PAPER WORKFLOWS

Problems You'll Encounter

As you know from reading through the Daily Chart Indexing and Filing section, these workflows can be very resource intensive. This paper must be scanned, indexed, filed, and tasked either at the clinic level or by a centralized HIM team. Remember, the faster you get documents and clinical data filed into your patient record, the better chance the information is available when the provider needs it. The longer your indexing and filing takes, the less likely the information is available when needed.

Why These Problems Occur

Despite the dream of a paperless office post-EHR implementation, the reality is that's just not reality. Most offices today are still utilizing paper forms each time a patient visits the office because it's the simplest method. These forms are often used for patient registration, internal clinical workflows, HIPAA acknowledgments, and more.

AUDITING TIPS

AUDITING YOUR PAPER WORKFLOWS

- ***Observe the workflow. Spend some time at a clinic observing the paper workflows each time a patient visits. Are the same forms always used? How and when does the information get entered? Is the document simply scanned in, or is discrete information updated in the system? How quickly does this occur? Could this form be electronic?***
- ***Determine the size of your issue. Take the number of paper documents each patient fills out during their visit and multiply that by the number of visits each day. Now imagine if clinic staff or HIM at all your clinics no longer had to scan, index or enter discrete information from all of those forms?***

5 LEGACY INFORMATION

Problems You'll Encounter

Storing legacy information of any kind, paper or electronic, can be risky, costly, and completely unnecessary. Think about:

- **Rising Costs**—storing paper charts in-house can create significant space issues and storing off-site and constantly retrieving charts from storage can be very costly as well.
- **Concerns over Accessibility and Security of Patient Information**—electronic information extracted from an old EHR system stored outside your current EHR, or scanned paper charts not stored properly poses security and accessibility concerns.
- **Increased Liability**—retention periods vary by state, but your organization may be hanging on to unnecessary information, further increasing liability.

Why These Problems Occur

Legacy information is any patient chart information that's not in your EHR system. If your organization is growing through acquisition or simply has historical paper charts or legacy EHR data, then this problem is affecting you.

AUDITING TIPS

AUDITING YOUR PAPER WORKFLOWS

- ***Determine if your organization is storing old paper charts. If so, where and at what cost? If you're storing charts, is it causing a disruption? Could the space be used for something more meaningful? Does your organization follow a retention/destruction policy? How are documents destroyed?***
- ***If your organization is acquiring practices, it's likely some were on different EHRs before the acquisition. Find out what happened with that information. EHR conversions are often plagued with issues. Did everything convert properly? Is anything still being stored electronically? How long does the organization have access to the legacy information for?***
- ***Review how the legacy information is being used. If your organization is storing legacy information in either paper or electronic form, is it ever accessed and how? Is the process simple or does it require many steps? Could it be better?***

FINAL STEPS

If you've made it this far, we hope you took notes! You asked questions, ran reports, did a little math and now what? Now, you review what you've uncovered and determine where your organization's biggest pain points are. If you haven't already, write them down:

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Congratulations, you're now one step closer to a BetterChart ™.

If you'd like to learn more, please visit **disccorporation.com** or give us a call at **800.710.3472**.