

Designing the Integrated Multidisciplinary Record Review

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Good documentation is a cornerstone of data quality. But how can an organization ensure that all disciplines will take responsibility for the comprehensiveness and accuracy of their documentation? The authors describe the steps one facility took to implement a process of record review involving numerous departments.

In May 1997, Crozer Chester Medical Center set a goal: to integrate various record review processes into a multidisciplinary record review owned by a number of disciplines within the hospital system.

This concept was supported by a project that had previously integrated progress notes. This project demonstrated that record documentation must be integrated for effective communication of pertinent patient information between various clinicians such as physicians, nurses, social workers, and therapists. Integration of the progress notes did not, however, ensure the comprehensiveness of medical record documentation of patient care. Each discipline determined and implemented its own standards for documentation and monitored compliance with those standards without coordination. As a result, there was no way to ensure the comprehensiveness of documentation and the reliability of reviews.

In recognition of this problem, the vice president of quality monitoring and improvement and the hospital services committee commissioned a team to develop a new, integrated medical record review. The assistant director of medical records and the hospital services quality assurance (QA) support specialist were designated facilitators of the team, which included representatives from all the clinical disciplines. The administration deemed this project an urgent priority and gave the team six weeks to understand the problem, develop solutions, and implement a pilot of a redesigned integrated multidisciplinary record review.

To work systematically, the team used the hospital's framework for individual and team problem solving and process improvement. This paradigm for quality improvement is built on a four-step key action plan based on elements from the book *Frontline Leadership: Problem Solving for Individuals and Teams*.

Key Action One: Description of the Problem

Limited Ownership of the Pertinence Review Process

Traditionally, the medical records department, as in most hospitals, was responsible for conducting monthly clinical pertinence reviews. These reviews typically evaluated medical documentation requirements as set forth by regulatory agencies such as the Joint Commission on Accreditation of Healthcare Organizations and the American Osteopathic Association (AOA). Annually, the medical records committee (composed of physicians from a variety of services as well as the vice president of patient affairs, director of nursing, vice president of quality monitoring and improvement, director and assistant director of medical records, director of insurance and claims management, and director of admission) would target the medical services to be reviewed monthly. The medical records department would implement that plan. Each month, the assistant director would review a random sample of 50 medical records, tabulate it, and submit the results to the committee. The committee would evaluate the results and notify individuals or services of documentation problems. The results of the clinical pertinence reviews were forwarded to the quality monitoring and improvement department (QM&I) and the medical staff services committee, which forwarded data to the board QA committee.

This process had some limitations. It focused upon individuals and rarely upon actual documentation processes as a reason for problems. The knowledge gained concerning documentation issues was limited to the medical records committee and the services or physicians reviewed.

Fragmentation of the Review Process

In addition to the pertinence review process, clinical departments within the hospital also conducted additional individualized, specific documentation reviews, which used a variety of criteria or standards. The documentation criteria were often problem focused rather than regulatory or standard driven.

Typically, departments conducted their own medical record reviews and evaluated their findings internally; as a result, each department was only aware of its own documentation issues. Findings were forwarded to the QM&I department and eventually to the board QA committee. Results were not shared with other departments and were not linked to other reviews.

The resulting improvement activities focused upon discipline-specific documentation process issues, which frequently resulted in the creation of discipline-specific forms. Numerous discipline-specific forms added complexity, rework, and confusion to the overall documentation process. Although the medical records committee approved all forms, there was limited awareness of their impact upon the departments' documentation outcomes and the overall documentation outcomes of the medical record. In addition, this complexity made reviews by other disciplines difficult, as other disciplines were not sure where certain pieces of pertinent patient care information should be documented in the medical record.

Audit Review Discrepancies

Members of these committees noted discrepancies between the departmental review results and the medical records review results. It was noted that departmental outcomes were often more positive than the outcomes of the medical records review. This raised questions regarding the validity and reliability of each review. Additionally, discrepancies were also noted between internal and external review findings. Administration noted that internal review processes did not provide a comprehensive understanding of the overall medical records "state of documentation," which made comparisons and correlation with the external reviews difficult and problematic.

Key Action Two: Identification of the Causes of the Problems

Knowledge Deficient of Documentation Requirements

Departments did not have a knowledge of regulatory standards and specific documentation requirements pertinent to their discipline. Although copies of the regulations were readily available, identification of the requirements was difficult and subject to interpretation. Despite the existence of integrated progress notes, many disciplines were unaware of—and did not understand the significance of—their documentation practices in relation to others' documentation practices and the overall documentation of patient care.

Variation in the Review Methodology

The discrepancies in review findings were attributed to the review methodology. Many departments conducted their reviews concurrently rather than retrospectively. This allowed disciplines to correct omissions or deficiencies prior to the closing of the medical record and may have skewed the data reported. (Retrospective reviews are conducted on closed medical records and generally report the outcome of whether criteria was met or not.) The reliability of the findings were jeopardized by a lack of defined sampling controls for the data collection (e.g., when, who, and what data is reviewed/collected and standardized definitions for the criteria).

The lack of correlation between the concurrent and retrospective reviews may also reflect deficiencies in sampling processes. Concurrent reviews used non-probability (convenience) sampling methodology, whereas the retrospective reviews used probability (simple random) sampling. Inconsistent sampling methodology did not provide controls for preventing variation in results due to other extraneous factors (e.g., missing reports) or sampling selection bias, which resulted in questionable or false-positive findings for many of the departments.

Key Action Three: Proposed Solution(s)

Integrate the Medical Record Review Process

To improve each department's awareness of chart documentation requirements and deficiencies, one overall review process was proposed. The review process would be the responsibility of many departments within the hospital. The process redesign team identified representatives from numerous medical and clinical departments who documented in the medical record; these people became members of the multidisciplinary review committee. The nature of the committee would allow areas that previously reviewed their own documentation in isolation to participate in the review of their and other disciplines' documentation, gain an understanding of all required elements of documentation, and view the documentation process as an integrated process of "handoffs" of pertinent patient information.

Develop a Comprehensive Medical Record Review Tool

The team identified the criteria for record review data collection that was appropriate to organizational needs by conducting a review of all standards—Joint Commission, AOA, state, federal, and other regulatory agencies applicable in this practice setting. All departments were surveyed to determine unique regulation requirements, which were incorporated into the development of the multidisciplinary record review. While the comprehensiveness of the review tool made it initially seem cumbersome, it would eliminate audit redundancy and increase efficiency by eliminating rework (e.g., pulling a chart multiple times so it could be reviewed by each discipline). A crosswalk among all the regulations and the review criteria was created to demonstrate the content validity for each item. Also included in the crosswalk was the designated location for each piece of documentation (See Exhibit 1).

exhibit 1—Crosswalk Tool

MEDICAL RECORD DOCUMENTATION REVIEW						
Item	Standard	Criteria	Location in Record	Yes	No	N/A
1	IM 7.1 IM 7.2	Face sheet signed/dated	Face sheet Tab #1			
2	IM 7.2 RII 2.4 IM 3.2.1.2	Final diagnosis present on face sheet	Face sheet Tab #1			
3	IM 7.2 RII 2.4	Advance directive status/documented	Nursing admit record Tab #2 Admission database Tab #3			
4		Organ donation status documented	Admission database Tab #3			
5	IM 7.2 RII 2.4	Admission consent signed by patient/guardian	Pt. auth. form/EE consent Tab #4			
6	MS 8.2.3	Overall the penmanship of the record is legible	Review entire chart			
7	IM 7.6 PE 1.6.1	History and physical completed within 24 hours of admission	Date on H&P Tab #5			
8	MS 6.2 IM 3.2.1.2	Chief complaint noted in history and physical	H&P Tab #5			
9		Review of system noted in history and physical	H&P Tab #5			
10		Family history noted on history and physical	H&P Tab #5			
11		Past medical history noted on history and physical	H&P Tab #5			
12	CC 2	Conclusion/reason for admission noted in history and physical	H&P Tab #5			
13	PE 1.6.1	Nursing assessment completed within 24 hours of admission	Admission database Tab #3			
14	PE 1	Physical status assessment noted in nursing assessment	Admission database Tab #3 Adult care flow sheet Tab #11			

Standardization of Methodology

The integrated record review was planned as a retrospective review of closed medical records. To control for sampling bias, a stratified random sampling of medical records was used for the review. A stratified random sample, while allowing for targeting of certain populations (services), also provided each element of the population an equal chance of being selected and would produce a representative sample. The records for the review were pulled by the medical records staff, using a specific sampling criteria, under the supervision of the assistant director of medical records. The sample size was calculated by determining whether a 5 percent sample of the total monthly discharges for the targeted service was greater than a minimum sample of 30 records (the appropriate size was whichever was larger, since the larger the sample the smaller the sampling error).

exhibit 2— Scannable Survey Tool

MEDICAL RECORD DOCUMENTATION REVIEW			
Medical Record Number _____			
Discharge Date _____			
Attending Physician Name (Number) _____			
Please select one response for each question. Additional information may be documented on the comment sheet.			
General Items			
Scale Definition: 1-Yes 2-No 3-N/A	1	2	3
1. Face sheet signed and dated?	☐	☐	☐
2. Final diagnosis present on face sheet?	☐	☐	☐
3. Advanced directive status/document noted?	☐	☐	☐
4. Organ donation status noted?	☐	☐	☐
5. Admission consent signed by patient/guardian?	☐	☐	☐
6. Overall penmanship of the record is legible?	☐	☐	☐
Assessment Items			
7. History & physical completed within 24 hours of admission?	☐	☐	☐
8. Chief complaint noted in H & P?	☐	☐	☐
9. Review of systems noted in H & P?	☐	☐	☐
10. Family history noted in H & P?	☐	☐	☐
11. Past medical history noted in H & P?	☐	☐	☐
12. Conclusion/reason for admission noted in H & P?	☐	☐	☐
13. Nursing assessment completed within 24 hours of admission?	☐	☐	☐
14. Physical status assessment noted in nursing assessment?	☐	☐	☐
15. Social status assessment noted in nursing assessment?	☐	☐	☐
16. Psychological status assessment noted in nursing assessment?	☐	☐	☐
17. Mobility/functional status assessment noted in nursing assessment?	☐	☐	☐
18. As indicated by patient need, nutritional status (consult) is assessed and documented?	☐	☐	☐
19. As indicated by patient need, functional status (Rehab PM&R consult) is assessed and documented?	☐	☐	☐

Implementation of Scanning Technology

exhibit 3 — Analysis of Survey Results**MULTIDISCIPLINARY MEDICAL RECORD REVIEW**
MAY 7, 1997

Creation Date 4/30/97

Total Respondents: 30

First Respondent: 4/30/97 Last Respondent: 4/30/97

Time Interval: 4/30/97 to 1/1/99

Respondents this time interval: 30

1. Face sheet signed and dated?

Total responses to this question: 30

1 - Yes 28 93.33%

2 - No 2 6.67%

3 - N/A 0 0.00%

2. Final diagnosis present on face sheet?

Total responses to this question: 30

1 - Yes 30 100.00%

2 - No 0 0.00%

3 - N/A 0 0.00%

3. Advanced directive status/document noted?

Total responses to this question: 30

1 - Yes 27 90.00%

2 - No 2 6.67%

3 - N/A 1 3.33%

An initial pilot of the multidisciplinary review record tool indicated that its comprehensiveness was cumbersome for both the data collection and analysis processes. The team, committed to the goal of an integrated record review, decided to use scanning technology to assist with both processes. The tool was reformatted using a software program to create a multi-page survey tool that required the reviewers to darken in the circle that best represented their response for each review criteria. The responses options were "yes," "no," and "n/a." Additional comment boxes were available for identifying other issues (See Exhibit 2). The completed review tool was processed using the scanner, and data was entered into a database, allowing for analysis and trending of data over time (See Exhibit 3).

Key Action Four: Plan Implementation

Education for the Integrated Review Process

A teaching book was created for initial training sessions and for use as a reference for subsequent reviews. The book was divided into three parts: the process, the tool, and examples of documentation forms.

Part One outlined an orientation to the integrated review process, describing the purpose, the review committee membership, the review schedules, guidelines for interpretation and determination of the appropriate response for review items, and the reporting process for the review data, as well as the hospital's policy on confidentiality and conflict of interest.

Part Two included the original review and crosswalk tools and a closed record order index. The order index was intended to familiarize the reviewers with the organization of the closed medical record (which differs, in our hospital, from the order most disciplines would be familiar with).

Part Three contained examples of actual documentation forms approved for use within the medical record. Each form noted the exact location for documentation, which was numbered to correspond with each item/criteria.

The orientation process included the use of overheads to walk each reviewer through each criteria/item of the multidisciplinary review tool; indicate who required each item of documentation; and identified the designated location or form for each item of documentation. Lastly, the closed record order index was used to train reviewers to find the form in the closed medical record.

Review committee members were required to attend one of two educational sessions provided on the integrated review process. No reviewer could participate in the integrated review process without attending an orientation session. The orientation and demonstration of the guidelines for data interpretation helped establish reliability among the reviewers and support for the integrated process.

Formation of the Multidisciplinary Review Committee

It was decided that the integrated record review would be conducted by a multidisciplinary review committee, a subcommittee of the medical record committee composed of representatives of the medical and clinical disciplines and representatives from the medical records department. Participants would include staff members who were not only the users of patient care documentation but who were also responsible for providing it. The assistant director of medical records coordinated the review schedule by ensuring the availability of the sample of records and notifying members of the date, time, and location of the review. A required quorum of representatives from each discipline was established for every record review session. Each discipline was encouraged to designate and train multiple reviewers and to rotate attendance at the review sessions. This prevented attendance problems and facilitated the spread of knowledge acquired from the integrated review process. Managers were responsible for ensuring that representatives of their disciplines were available for participation. A large quorum created a favorable work load distribution, as the size of the committee required each reviewer to conduct only one to three reviews per session.

Pilot the Multidisciplinary Review Tool and Process

Two review sessions served as the initial pilots of the integrated review process. The first used the original crosswalk tool, and the second used the revised scanning tool. The review subcommittee provided feedback to the improvement team. Forwarding Results/Closing the Loops The results of the integrated record reviews were presented to the medical records committee for discussion, interpretation, and identification of trends or patterns of performance relating to documentation. The committee also reviewed a sample of records for specific examples of the documentation issues identified by the multidisciplinary review committee. This process allowed the medical records committee to validate the results and effectiveness of the integrated process. The multidisciplinary composition of the committee facilitated immediate problem solving and the dissemination of the results to all medical and clinical disciplines. Copies of the review results were forwarded to the QM&I department, which then looked for appropriate department-specific follow-up in the departmental quality monitoring activities or the medical peer review activities. The hospital services committee and the medical staff services committee, along with the medical records department, initiated and coordinated any additional improvement activities.

Conclusion

The integrated multidisciplinary review process has increased the ownership of documentation and assigned accountability to the various disciplines. During the review sessions, committee members frequently ask a representative of a specific discipline to assist in determining the score for an item that does not appear in the designated location, and the team member must account for his/her peers' documentation practices. When the review team members return to their departments, they can immediately begin to address the issues identified during the review with their peers. As a result, turnaround time for positive changes in documentation practices has decreased, since departments may begin to improve practices prior to the actual release of the monthly record review results to the committees.

The results of the reviews demonstrate quantifiable improvement in the item scores for some of the previously deficient criteria and items. The integrated nature of the redesigned review process does make it difficult to compare current performance with previous patterns of performance, as there is only one year of data to serve as a baseline. It is expected that the variances demonstrated in the documentation process will diminish, and that the comprehensive record review will demonstrate a stable process for all criteria as data is gathered over time. Variations in performance may be reviewed to determine special causes or process issues that can be improved, and the review process will continue to move from focusing on individual practices to focusing on the actual processes of documentation.

The integrated multidisciplinary record review has successfully bridged some of the barriers between disciplines. The integrated process has created a broader understanding of the requirements that relate to the documentation process. Additionally, the integrated review process has demonstrated to reviewers the complexity of the documentation process and the inefficiency of certain processes, particularly those that involve duplication of documentation. The integrated review process may be a stepping stone to the actual redesign of a truly integrated documentation process of patient care.

Acknowledgement

Special thanks to Marc D. Edelman, vice president, quality monitoring and improvement, and Raymond Pinder, MS, RRA, director of medical records, Crozer-Chester Medical Center, Upland, PA, for their support of this project.

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Article Citation:

Bisbee, Jr., Walter L. and Debra Harris Lillback. "Designing the Integrated Multidisciplinary Record Review." *Journal of AHIMA* 69, no. 6 (1998): 54-60.

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