Pursuit of Excellence in Medical Record Reviews

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The Pursuit of Excellence in Medical Record Reviews

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The ongoing medical record review program at Sioux Valley Hospital USD Medical Center needed reenergizing: the results weren't taken seriously or producing the needed improvements. Using tools from the Joint Commission, an HIM professional and a performance improvement coordinator redesigned the process, making it more efficient and more effective. Here's how they did it.

Is your ongoing medical record review (MRR) process producing meaningful results? Are you able to use the data collected to improve documentation and ultimately, patient care? Are your record reviewers comfortable making decisions and able to meet their deadlines? If not, it may be time to take another look at your facility's MRR process.

At Sioux Valley Hospital USD Medical Center, our ongoing MRR program was piecemeal and clumsy. As the largest medical facility in the region with approximately 476 beds, we had 22,438 inpatient discharges and outpatient activity that resulted in 81,002 actual outpatient medical records in 2001. Our MRR program involved members of the nursing performance improvement (PI) council with additional multidisciplinary members to review 30 to 50 closed records every other month with the Joint Commission surveyor's entire record review tool. This process had several shortcomings, including a lack of ownership and meaning to the results obtained. Results were not valued because participants felt that the sample size was too small. Further, tallying and aggregation of results required much validation and re-review of records by the coordinators of the process.

We had resisted establishing a new program because of the significant time required. Moreover, we weren't convinced that the new program would be more valuable. However, we recognized the need to change the process when the same problems were found repeatedly in the records, despite calls for action from all departments. Additional motivation came after our Joint Commission survey in 1999. The surveyor identified three issues we needed to address:

- develop our program to provide more trended information
- give more focus to clinical pertinence
- show more documented performance improvement

We decided to design a new ongoing MRR that would be more meaningful to the reviewer and use a more representative sample of records closer to the point of care. The new program became an organizational priority, but no additional resources were available to make it happen. We had to capitalize on existing structures, functions, and resources.

Defining Our Goals

We began by conducting an in-depth review of the Joint Commission standards, scoring guidelines, and intent statements; Centers for Medicare and Medicaid Services conditions of participation; state regulations; and our facility's policies, rules, and regulations. Then, together with the vice president of clinical services and the HIM director, we established goals and objectives for an ongoing MRR process. The goals included:

- define representative sample size for hospital (5 percent was ideal)
- include inpatient and outpatient records in monthly documentation reviews
- incorporate timeliness of documentation monitoring
- provide trended data for analysis and prioritization of improvement opportunities
- provide analysis of aggregate data using Joint Commission scoring guidelines as benchmark
- meet the Joint Commission requirement for a multidisciplinary approach by requiring those who provide the care to conduct the reviews
- shift the focus of reviews to the point of care: the open record
- use the entire Joint Commission review tool and incorporate hospital-specific items and the 19 required elements
- promote action plans and remonitoring to show achieved and sustained improvement

In addition to complete support from management and administration, it was clear that a full multidisciplinary team would be needed to carry out the new MRR process. Our new team consisted of nursing PI council members, representatives from all ancillary areas, physicians, HIM, and PI staff. Further, it was critical to be able to produce department-specific as well as aggregate results for the process to be meaningful and provide desired outcomes. Timely, regular communication of results would be key to a comprehensive process. Finally, this program had to be efficient and simple to implement.

Steps Toward Implementation

Sample Size

Establishing the monthly review sample size to fit our organization was our first hurdle. We wanted to ensure that we reviewed a large enough sample twice a year to start some meaningful trend lines, so we chose to review 5 percent of records monthly, with each team member reviewing 10 records per month for a particular element of the record. Because using additional staff to conduct the reviews was not an option, we had to use existing staff in a more creative manner. We were given the autonomy to design a program that would fit into our existing clinical environment and established workflow.

Timeline

The initial timeline for the pilot study was July 2000 through December 2000. We would then test the data, evaluate the program, and survey reviewers for improvement suggestions. January 2001 through June 2001 completed the second cycle of this first-year phase. By July 2001 we considered our program fully implemented with trended data for comparison and reporting mechanisms established.

Review Tools

To review open and closed records, we downloaded the Joint Commission Hospital Surveyor Medical Record Review Tool. The tool is designed to allow the reviewer to check for the presence or absence of key elements in the medical record. To work effectively with a multidisciplinary group, we needed to reengineer the tool to be more user friendly. We divided it into four sections and assigned each section to two months:

- assessment of patients (January and July)
- documentation of care (February and August)
- education (March and September)
- operative and invasive procedures (April and October)

We knew that verbal orders (May and November) and nursing assessment documentation (June and December) were two important areas for our organization so we developed a separate review tool for each. For the clinical pertinence reviews, we developed our own tools to cover the remaining elements on the 19 required elements. Legibility and HIM indicators (documentation timeliness) reviews are addressed outside this structure and the results are then incorporated into the program.

Then, after a detailed analysis of the earlier MRR process, we created binders for the open record review for each reviewer. Each binder included the assigned tool for each month, guidelines for each of the review elements, action plan forms to record any items found that required improvement, and pre-addressed envelopes to submit the original review tools. We initially prepared these binders for a six-month trial knowing that the Joint Commission Web tool changes frequently and to determine which information would be important and valuable to our organization. The binder enabled the reviewers to review their 10 charts anytime during the month, instead of at one designated time.

The focus studies on clinical pertinence involved the members of our multidisciplinary team that didn't have specific outpatient visits, such as the pharmacy, HIM, and PI. This focus group reviews different report types for content on a regular basis and much of the review is done on closed records (the autopsy and donation sections on the required 19 elements by nature can't be reviewed on an open record). The MRR program captures the record as soon as possible after discharge to get as close to the open record as possible. This focus group has evolved as HIM students on their clinical rotations participate in this process.

Next, we established tools to monitor the MRR process. To increase the likelihood of getting solid, factual results, the reviewers needed education and guidelines to follow at every step, especially because there is turnover in PI positions every year. We met with each reviewer, established monthly information sessions, and e-mail and phone "hot lines" for questions and changes.

Tallying the Results

The review tools incorporated a tallying component, which was a manual process throughout the development of the program. Now, we use a computerized tally component for easier data compilation. We learned an important lesson while developing this portion of the tool. Although we give the reviewers only three options for an answer ("N" means that the element did not apply to the record, "P" means that the element is present, and "A" means that the element is absent) and guidelines to make judgments, we initially received many written comments on the data collection tools. This made the tally process more time consuming and we realized the reviewers needed to feel more empowered to make decisions.

At the monthly nursing PI council meetings, we reviewed the results and explored details of the reviewers' concerns. As the reviewers became more comfortable with the review process, they also became more comfortable making their own judgment calls and discussing them. They realized that this new program was an avenue for learning, not criticism. We no longer felt compelled to re-review records.

Tracking and Trending the Data

To make our statistics measurable and trackable, we decided to convert our data into percentages. Then, once the data was ready to be disseminated, we wanted to benchmark it. We also wanted to show the nursing departments how they were doing with documentation each month by giving them an overall score. We decided to "score" each review and compare it to the Joint Commission scoring

guidelines as a benchmark (see "MRR Scoring Formula" below). This method proved quite successful, especially at the administrative level. By trending aggregate data, we were able to see the individual departmental improvement opportunities. Directors were encouraged to keep copies of their own department's review results in order to establish their own thresholds and monitor progress by comparing current results to their previous results and identify and address their own department-specific PI opportunities.

By viewing the aggregate data, reviewers could more easily determine if data collection done on their unit was accurate. Because of the open communication structure we established, reviewers were able to ask questions about whether their interpretation had been accurate.

The staff learned that some of the elements were outside their control, but because they affect everyone across the board, we are still comparing like scores. The reviewers and the directors could then also compare their scores to the scores of the other nursing departments. The next time these elements were reviewed, they could see their overall improvement.

An essential component in gathering and reporting statistics is our master review book that includes all record review activities. It incorporates our policy, review plan, the documentation of the percentage of records reviewed each month against that month's discharges, the listing of the members of the multidisciplinary team, the summary checklist for the 19 required components, the schedule for review including the draft for the year's focus reviews, review results, the reporting and action taken, and a final section for evaluation and success stories.

Maintaining Progress

Once we established the review program, we needed ways to maintain its effectiveness and keep reviewers motivated. When a department shows a gap between its actual performance score and the benchmarks, it is documented on an action plan. The action plan form identifies the problem, to whom the problem was referred, and the action taken. Then, a follow-up is planned before the next scheduled review. Additionally, the process enables the department to devise its own strategy and re-review of missing elements prior to the next hospital-wide review in six months.

Occasionally, reviewers are too busy to complete their reviews and do not send them in. To address this complaint, we send e-mails to the directors of departments listing the non-reporting areas after each tally. The directors' follow-up sends a clear message to reviewers that this program is a priority. Equally effective is posting the results in each committee meeting. When a department fails to submit its results, "No Report" is listed next to its name on the results projected to the entire group. This is necessary to keep our representative sample size for the Joint Commission and to get a good cross section of our overall hospital performance.

Another way ongoing progress is ensured is through support from administration. Each month, we report the MRR findings to nursing senate and patient services directors in addition to our monthly hospital-wide nursing PI council meetings. Upper management leaves no doubt that this is an organizational priority now that we have the tools necessary to determine our PI opportunities. All results from the ongoing MRR process are also reported into the medical record committee. Physicians then review the aggregate results and records are brought in for their detailed review. Action for the physician component of the review lies with this committee and the chief medical officer who sits on this committee.

Impact

Looking back, we feel fortunate that the Joint Commission prompted us to improve our MRR program. The benefits we have realized over the last two years with the new MRR program have gone beyond our expectations. One of the major benefits has been increased efficiency in the review process. Because documentation has improved at the point of care, it requires less monitoring. Now, reviewers

spend approximately two hours per month resulting in a total review of 400 to 500 records per month. And because the records are reviewed by those who actually use them, there is a heightened awareness of documentation expectations.

Further, the unit-specific results enable staff to aggregate and track their own progress over time. The immediacy of the results promotes sustained performance improvement for a department and also for the entire organization.

The required action plans have increased the effectiveness of performance improvement measures. The best part of the action plan process is that it is easily incorporated into our existing PI program. Denial of problems has been replaced with the realization that there are opportunities for improvement. While it took some time for the action plans to be accepted at the facility, administrators realized the value of promoting the process. In fact, there were several requests to use the same format for other PI activities. Due to the information gained from these reviews and the resulting increased awareness and education, pain assessment documentation went from 84 percent to 96 percent.

We continue to update and revise the ongoing MRR program. Review tools are updated as the Joint Commission revises its tool. Guidelines are also updated as indicated and at the suggestion of some reviewers. Equally important, the results from this process are evaluated monthly and the process itself is evaluated annually with an informal survey sent to all reviewers, Joint Commission chapter committee chairpersons, directors, and administrators. We want to ensure that we continue to provide valuable data and meaningful information. The individual department binders are considered innovative as a result of analyzing existing processes in such detail prior to implementation of this process. Another innovative component of the ongoing MRR process is the ease in developing focused studies. Clinical pertinence indicators are mostly reviewed within focus studies now.

The most exciting part of this process has been the education all of the stakeholders have received. We've heard several comments like, "I didn't know I was supposed to document that!" Complex performance improvement projects involving multiple stakeholders can only achieve success with small, incremental changes. We believe the continuous monitoring and frequent evaluation of this process has been key to our success.

MRR scoring formula

150 (total number of review elements) - 50 (not applicable elements) = 100 (elements that apply)
100 - 10 (absent elements) = 90 (present elements)

$$\frac{\text{90 (total present elements)}}{\text{100 (elements that apply)}} = \text{90 percent (score)}$$

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