

# Forging a Path to the True Legal Health Record

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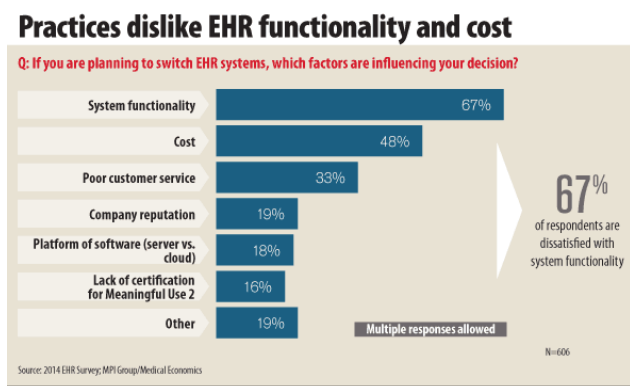
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Paper and electronic health records (EHR), or a combination of both, provide supporting documentation and records information about a specific episode of care. The record must tell the story of the patient from the initiation of a health care encounter until the patient's discharge from the encounter, whether the encounter occurs in an inpatient, outpatient, or professional practice setting or in some other non-acute or post-acute care setting.

The transition from paper to hybrid to the electronic record has not occurred smoothly, and that reality is creating a new problem for hospitals across the country. Clinical providers and supporting staff have expressed great dissatisfaction when they discover that many of the expensive EHR solutions in the market today do not support the functionality needed for an efficient and effective workflow.

A 2014 Medical Economics article included a recent survey of over 1000 physicians; the chart shown in Figure 1 identifies the reasons for this dissatisfaction<sup>1</sup>:



**Figure 1:**  
Reasons for EHR  
Dissatisfaction

## History

Meaningful Use<sup>2</sup> definitions and objectives were developed with the intent to qualify providers for Medicare and Medicaid EHR Incentive Program<sup>3</sup> rewards if providers adopt, implement, or upgrade to demonstrate Meaningful Use of certified EHR technology. These objectives focused on generic clinical goals of quality, patient care, privacy/security and safety but did not identify requirements to support the legal health record (LHR) from a workflow perspective to achieve those goals.

Many of the Health Information Technology system vendors focused their EHR solutions more upon data input as opposed to output of printed documents and reports; dynamic template displays instead of stable forms management; and longitudinal rather than episodic capture. Hospitals and physician practices were encouraged to quickly choose and install solutions to meet arbitrary deadlines and qualify for the incentive program. Since these EHR systems were developed with a focus on discrete data collection as opposed to adequate document management and workflow, the providers were able to perform longitudinal comparisons of data and do away with many of the constraints of access that occurred with paper charts. However, since these same EHR systems did not have a solid foundation of record keeping principles and good forms management within their design, the systems did not support workflow to the level that Electronic Document Management Systems (EDMS) do.

<sup>1</sup> <http://medicaleconomics.modernmedicine.com/medical-economics/news/slideshow-medical-economics-ehr-survey-probes-physician-angst-about-adoption>, February 10, 2014

<sup>2</sup> <http://healthit.gov/providers-professionals/meaningful-use-definition-objectives>

<sup>3</sup> [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/01\\_Overview.asp](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/01_Overview.asp)

## Challenges

Aside from the dissatisfaction experienced by the clinicians, Health Information Management (HIM) professionals also experienced problematic workflow in the management and maintenance of the legal health record due to fragmented and incomplete record management structure. The EHR solutions that rapidly came to market and had been initially viewed as the potential "total solution" for a facility's medical record needs were soon discovered to be less than adequate for long term Legal Health Record management and workflow needs. The rush to install these systems and the general lack of understanding or consideration for using a document-based solution resulted in unintended consequences. A hybrid or fragmented environment was created, which in turn, produced a sub-optimal platform that could not support the complete workflow necessary for Health Information Management functions and record processing activities. The ideal health information management system supports workflow from initial record creation all the way through purging of archived documents within the health record. It also provides a complete story of the encounter that includes auditing tools, reporting, and robust release of information tools to support record disclosure that is consistent with hospital policies and defensible in the case of legal action.

These early EHR systems adequately met most of the Stage 1 criteria addressed in the Meaningful Use definitions and allowed organizations and clinicians to obtain the promised incentive funding provided by the government program. Unfortunately, moving to a more advanced stage was more difficult for many of the facilities who chose to be early adopters because of the lack of a viable infrastructure and foundation in the EHR upon which to build and support document and data integrity.

Some facilities are searching for replacement systems, while others are searching for an additional software solution similar to the way PACS (picture archival communications systems) became the replacement for radiology films alongside the Radiology Information System (RIS). However, most EHR systems today, even those with higher physician satisfaction and confidence, are still unable to support a stable, document-based legal health record. The legal health record allows for rapid access to all documents in the patient record from a single location for both viewing and release of information purposes. The ideal solution to help make the leap and cover the gap from the dynamic, discrete data system to an episodic, document based system is an electronic document management system (EDMS).

## The Optimal Solution

A Level Three<sup>4</sup> Electronic Document Management solution (See Figure 2), existing alongside and acting as a complement to the EHR, provides the ideal way to collect flexible data, create documentation with the active patient care record, and capture it for post-discharge HIM workflow as well as long term reference and archival purposes. Service Oriented Architecture (SOA) approaches can provide a single front-end user

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<sup>4</sup> Grzybowski, D. 2014. *Strategies in Electronic Document and Health Record Management*. Chicago: AHIMA Press

interface for clinicians during the documentation process itself. But the key to a robust EDMS solution serving as the Legal Health Record is to ensure 100% of all final documents, reports, and template output are captured into a stable, printable, working Legal Health Record, with the ability to index, access, and purge or destroy individual episodic records as needed to comply with release of information and retention guidelines. *This is a critical change in thinking from previous strategies of EHR standalone solutions that did not centralize all document management activities and workflow to support the functions around management of the true Legal Health Record*

An EDMS is not synonymous with a scanning/imaging solution. The EDMS is a more robust cousin containing full software functionality that includes but goes beyond providing document scanning and indexing. A Level 3 EDMS includes support for other key Health Information Management data and document integrity workflow requirements such as Census Reconciliation, Deficiency Analysis, Incomplete Record Processing, Coding, Abstracting & Clinical Documentation Improvement, Release of Information, Medical Transcription, Decision Support, and Performance or Quality Management.

Many healthcare organizations are also exploring and implementing ECM (Enterprise Content Management). ECM pushes the document management concept to an even more advanced level, by capturing documents and content in other paper and electronic systems to insure interoperability between systems and departments. For example, by using ECM within a hospital Billing Department, billing staff may share remittance documents received electronically from third party payors with the HIM department, use workflow to streamline and automate the working of denied or rejected claims, and access the necessary HIM documentation in order to effectively appeal problem claims. ECM improves workflow and productivity, and optimizes hospital investments in technology.

Information governance over the health record is a key responsibility for the custodian of the record, who is typically designated as the HIM Director of an organization. The HIM Director defines standards and processes for format and use, content creation, forms design, completion, release, privacy, access, print control, archive, retention and purging. The HIM Director also sets standards for the organization via policies and procedures utilized in the workflow software for supporting master patient index validation and modifications, workflow routing, incomplete record management, coding & abstracting, retrieval & release of information, archive, and purging of documents.

Figure 2 illustrates how Level 3 systems work most effectively to support best practices in Health Information Management and mitigate risk in record management. A complete document management solution helps to ‘defend the record’ and the individuals responsible for the documentation in those records during any litigation by accurately displaying all entries and modifications to the final discharged Legal Health Record.

## Electronic Document Management System Model

### Level 3

- 100% Optimized Functionality
- Dedicated EDMS software with workflow integration
- Full COLD interfaces from all systems
- Scanning functionality
- Reporting functionality
- Full Legal Health Record support

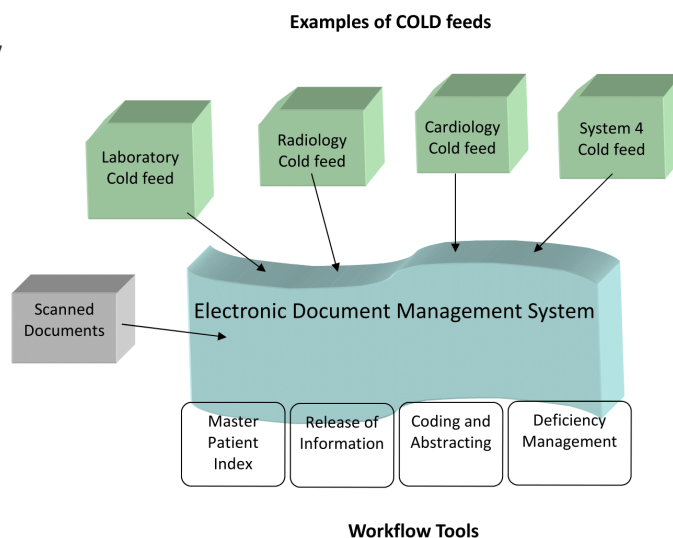


Figure 2:  
Level 3 EDMS  
System Model



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## Conclusion

In a July 2014 article entitled “How Records Management Can Serve Two Masters”<sup>5</sup>, Amanda Griffith notes, “Today’s records management challenges reflect a system in transition. Because information creation, storage, and use still are decentralized across many applications, a great deal of thought must be given to how to approach it across organizations. Providing guidance and establishing policy on the long-term preservation of information must be a priority.” She continues with, “How will legacy records be stored and archived? What steps are necessary to make the organization compliant with retention laws?”

The answer is clear and lies with the Electronic Document Management System, a mature solution that provides the stable foundation, infrastructure and workflow support for the LHR that is critically missing from most EHR’s today.

<sup>5</sup> Griffith, S. “How Records Management Can Serve Two Master”, July 2014 [www.fortherecordmag.com](http://www.fortherecordmag.com)

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