Does HIM need to be a storefront operation?

by Lynette Kramer, MA, RHIA

The significant market, technology, and regulatory challenges affecting healthcare are influencing what services are provided by the HIM department. The organization and delivery of HIM functions is changing from a storefront HIM department model to virtualization and consolidation of functions, some of which might not be aligned under HIM.

Two of the significant drivers of change are the Affordable Care Act (ACA) and the arrival of the fourth industrial revolution. The implementation of the ACA has led hospitals to find ways to reduce costs as margins decline. As a result, there has been an increase in mergers and acquisitions, which provides an opportunity to consolidate functions and departments. The fourth industrial revolution is also having a major impact on HIM by automating workflow and functions.

Taking today's challenges head on will demonstrate the HIM professional's ability to adapt to a changing landscape and provide its organization with a reduction in operating costs and the provision of superior service. Centralization (virtual and physical) has many benefits; however, a shared services model should provide benefits beyond centralization. A shared services model should:

- Prioritize the end user by focusing on the needs and challenges of local entities
- Continuously identify areas of performance improvement
- Actively engage in the achievement of strategic goals
- Use leading practice processes

The preferred outcomes of moving to a shared services model include:

- Gaining economies of scale—a proportionate saving in costs as a result of an increased level of production
  - Labor cost reductions achieved through improved productivity and increased span of control
  - Improved vendor performance
  - Balanced workload
- Providing consistent service delivery to patients, employees, vendors, and clinicians
  - Quality
  - Satisfaction
  - Process variation elimination
- Use of specialized business functions

Transcription and coding units have historically been the two areas for consolidation and centralization. The consolidation and centralization of the other HIM functions has been limited due to, in part, the reluctance to eliminate the storefront HIM department. The ability to fully consolidate and centralize the remaining HIM functions is dependent on how far along the organization is on its EHR journey and sometimes the distance between facilities. Consider the following when evaluating and planning for centralization.

Document imaging

The need for large document imaging units has decreased significantly over time because of direct provider input into the electronic record and the availability of lab and other reports in the EHR. Consolidation and centralization considerations will be dependent on the volume and geography of the facilities in the health system. At a minimum, the quality assurance function should be considered for centralization.

- Do you know how the number of sheets and the types of forms you are receiving post-visit for each major patient type?
  - Could these be eliminated by creating templates?
  - Could they be scanned at the point of care?
- Depending on the volume of loose sheets to be scanned, should centralized prepping and scanning be considered (should high-volume facilities consider centralization of prepping and scanning)?
  - Are the facilities within a reasonable proximity to retrieve and process sheets within 24 hours of care?
- Could job sharing with another department be leveraged to assist in loose sheet retrieval and/or local prepping/scanning?

Data integrity (EMPI, MPI management, data exchange management)

Improved efficiencies in other HIM functions provide an opportunity to realign staff to focus efforts on the enterprise master patient index (MPI). It is important to assess what the resource requirements are prior to establishing the consolidated unit.

- What is the current volume of duplicates, overlaps, and overlays, and what are the labor requirements to manage that volume?
- Is there a backlog in staffing?
- Are there ancillary systems that have to be updated manually vs. the EHR? Can these systems be integrated into the data integrity unit?
- Are there full-time employees who perform data integrity functions, or are these functions part of another role at each facility or practice?
- Can data integrity be part of a telecommuting program?
- Does this function have synergy with transcription?

Deficiency management/physician suspension

There is often reluctance to centralize this function because of different medical staff bylaws and rules and regulations across a health system; sometimes it's not possible to eliminate the physician record completion room. Today's workflow tools and rules-based deficiency management simplify this function dramatically, but it remains complex because of process variation among individual analysts. Conducting an in-depth analysis of each analyst's approach to his or her work is recommended to gain an understanding of the value of the work being performed. The analysis will also help identify opportunities to standardize and centralize this function while adding value to having a complete and accurate medical record.

- Do you know what each analyst is analyzing? Is it a qualitative review or a quantitative review?
  - Why is each analyst analyzing each deficiency? Is it improving the quality of the record entry?
- Are there opportunities to automate analysis further?
- How different are the deficiencies by facility and record type?
- How different are the physician notification procedures? Do they need to be different?
- Are physicians signing paper records/forms? If yes, why?

Release of Information

Release of information (ROI) is frequently cited as a major reason a storefront HIM department cannot be eliminated; however, those storefronts are often tucked away in the long and winding halls of a basement. Organizations should explore alternatives that provide a customer-friendly mechanism for patients to request copies of their medical records.

- What is the number of requests processed while the requestor is waiting?
- What is the number of walk-in requests?
- How many walk-in requests are processed the same day?
- How effective is the organization's patient portal?
- How can technology be used to eliminate a reception desk?
- How can clinical departments or revenue cycle staff (e.g., registration) be leveraged to connect patients to a customer-friendly ROI center?

The ROI team often is responsible for staffing for incoming calls. The transition plan should include moving to a centralized intake function across the facilities. An opportunity also exists to integrate this intake function with the customer service unit of patient financial services, thereby leveraging technology and staffing.

Implementing a shared services delivery model is a journey with many dependencies on how quickly you get there. By keeping the destination in mind and exploring non-traditional service delivery options, an organization can accelerate realization of the benefits: cost reduction, consistent quality service, and specialization of services.

EDITOR'S NOTE

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