



news

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A Better Way to Measure and Understand Inpatient Documentation

*Summer Issue of Perspectives in HIM Features Research on
Documentation Improvement, ICD-10 and Interoperability*

CHICAGO – July 16, 2014 – Whether the medical record format is paper or electronic, complete and accurate documentation is an important aspect of patient care.

The summer issue of [Perspectives in Health Information Management](#), the American Health Information Management Association's (AHIMA) online research journal, features a study that describes a new metric to measure documentation, termed the "normalized case mix index." The tool enables analysis of whether documentation improvement efforts are successful from standpoints such as quality, acuity and reimbursement.

The study found that clinicians benefited significantly by working directly with the coding and documentation improvement professionals who provided insights into enhancing documentation in ways that improved communication in the medical record.

The normalized case mix index is explained in the study, "[Improving and Measuring Inpatient Documentation of Medical Care Within the MS-DRG System: Education, Monitoring, and Normalized Case Index](#)." MS-DRG stands for Medicare Severity Diagnosis Related Groups. The index allows comparison of hospitalizations across multiple unrelated MS-DRG groups. The authors propose that quality education focusing on relevant, common misses is more important than the quantity of education.

"Innovative research like this is hallmark of *Perspectives*, now in its 10th year of providing scholarly publishing that advances the health information management (HIM) profession," said AHIMA CEO Lynne Thomas Gordon, MBA, RHIA, CAE, FACHE, FAHIMA.

The summer issue also features the following articles:

- In a rapidly changing healthcare environment, not only must the HIM professional adapt but so, too, should educational program and training. The study, "[Perceptions of Health Information Management Educational and Practice Experiences](#)," examines perceptions of health information management (HIM) students, faculty and individuals employed in healthcare regarding educational experiences and career preparations. The research supports the corresponding roles that educational coursework and practical experiences provide for students as they enter the HIM workforce.

- The establishment of the Meaningful Use criteria has accentuated the urgency for interoperability of health records. The findings of the study, "[Personal Health Records: Is Rapid Adoption Hindering Interoperability?](#)," suggest that the deadlines for implementation to capture Meaningful Use incentive payments are supporting the creation of personal health record data silos, hindering the goal of high-level interoperability. The authors write that this stems in part because standardized code sets have been built for specific entities, but integration between them has not been supported.
- Longitudinal data comparisons are only reliable if they use comparability ratios or factors which have been calculated using records coded in both ICD-9-CM and ICD-10-CM. The authors write in the study, "[Projected Impact of the ICD-10-CM/PCS Conversion on Longitudinal Data and the Joint Commission Core Measures](#)," that to prevent errors in decision-making and reporting, all stakeholders relying on longitudinal data for measure reporting and other purposes should investigate the effect of the conversion on their data.
- How will coder productivity be affected during the lead-up to and in the initial stages of ICD-10-CM/PCS implementation? This question is explored in the study, "[Preparing for ICD-10-CM/PCS Implementation: Impact on Productivity and Quality](#)." The authors found that previous estimates of initial coder productivity loss may be understated. They noted that while not statistically significant, coders who received more extensive training were faster than coders who had only received basic training, providing a strong indication of significant return on investment for staff training time.
- Clinical documentation and health information portability pose unique challenges in rural areas. In "[Electronic Health Records and Information Portability: A Pilot Study in a Rural Primary Healthcare Center in India](#)," the authors write that physician encounters were entered into a web-based electronic record. Prior to the study, patients' medical information was normally recorded in a notebook that was returned to the patient. Some participants were also given a USB-based memory card that contained their detailed health records. The authors write that the dual portability model implemented in the pilot study demonstrates the utility of the concept.

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About *Perspectives*

[Perspectives in Health Information Management](#) is a scholarly, peer-reviewed journal, referred to by professors, professionals, public officials, industry leaders, and policy makers. Since 2004, it has been one of the most credible and respected journals of the HIM industry and is referenced in notable indices such as PubMed Central (PMC), the Cumulative Index to Nursing and Allied Health (CINAHL), and Google Scholar. [Learn more](#) about the submission guidelines and the manuscript review process. Join *Perspectives* in celebrating 10 years of scholarly publishing that advances health information management practice.

About AHIMA



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The American Health Information Management Association (AHIMA) represents more than 71,000 educated health information management and health informatics professionals in the United States and around the world. AHIMA is committed to promoting and advocating for high quality research, best practices and effective standards in health information and to actively contributing to the development and advancement of health information professionals worldwide. AHIMA's enduring goal is quality healthcare through quality information.

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