Optimizing Clinical Documentation within an Electronic Health Record System

Freed Associates assisted a medical center to improve its publicly reported quality scores through a clinical documentation improvement initiative that resulted in new guidelines for physician documentation in an EHR system.

Situation

A major goal for hospitals when implementing an EHR is to improve the efficiency of care and provide timely access to patient information, with the ultimate goal of increasing the quality of care. These goals were true for our client who installed their EHR system. After their go-live, this hospital noticed a negative change in a publically reported quality measurement. They contacted Freed to understand this concerning statistic.

After reviewing patient records and conducting interviews with physicians, nurses, coders, and quality management staff members, Freed concluded that the improper use of EHR features resulted in a decline in the quality of physician documentation. This impacted the ability to code all diagnoses and, consequently, affected the full and accurate severity of illness and thus the quality scores.

Freed determined that after providers started documenting in the new EHR, there was a lack of specificity, completeness, and clarity in their documentation, making it difficult for a coder to code the patient's complete condition. At the beginning of the project, a coder told us that they were looking forward to the EHR so they could read the handwriting. After implementation, coders could read the notes, but they reported that the

documentation was often redundant and cumbersome to read.

Freed concluded that the issues with physician documentation were multi-faceted.

Physician documentation best practices and standards were not formally defined, so physicans were unclear about allowable data for the patient's legal medical record. For example, one physician pasted an outside journal article into a patient's progress notes as part of her documentation. This would not have occurred prior to the implementation of the EHR when the physician's note was handwritten.

Previous training offered to physicians did not include best practices and standards or how a physician note should look or what it should include. Instead, training focused on how to navigate the system, how to place orders, and what to do when a patient was admitted or discharged. Additionally, physicians interviewed indicated the original training agenda contained very little content on how to use key features (such as problem lists) and how to keep certain patient data current.

Solution

There are many users of physician documentation, including other physicians, nurses, coders, and billing representatives. Each party has a vested interest in what is contained in a physician's note. Documentation must be clear, concise, complete, and consistent, and we learned that each party has a slightly different interpretation of those criteria.

Freed's recommendation to the hospital was to form a multi-disciplinary clinical documentation improvement committee. The goal was to gather research on what constituted an 'ideal' note from a physician, coder, care management, and quality perspective and determine the approach for retraining physicians on the agreed upon standards.

Freed led the committee through the development of new guidelines and physician training materials. We performed industry research on documentation best practices, cloning guidelines, and coding compliance and worked with the hospital to incorporate the Meaningful Use requirements for maintaining the Problem List in physician documentation.

Freed worked with the committee to design and develop a new inpatient progress note template and partnered with hospital leadership to draft a professional staff clinical documentation standards policy. We participated in the one-on-one physician retraining effort for the new, best practice standards.

As part of the follow-up QA process, Freed worked with the clinical documentation specialists to focus their chart reviews on the retrained physicians to confirm that they were adopting the new standards.

Results

Our work helped set the expectation and further the transformation of physician documentation for this client. The hospital continues to invest in training for all physicians, and quality scores started to noticeably improve.

Using Freed's guidance, the hospital invested in implementing other features within the EHR to improve current documentation and allow providers to transition more smoothly to ICD-10 when expectations for additional specificity in physicians' documentation increases.

