Curing Inherited EHR Ailments: EHR Remediation Fixes System Issues and Better Aligns Clinical Workflow with Clinical Documentation

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In recent years the introduction of the American Recovery and Reinvestment Act's (ARRA's) "meaningful use" EHR Incentive Program has encouraged more healthcare entities to chart their course toward electronic health record (EHR) system implementation, taking advantage of the opportunity for incentive payments to support the high price tag of an EHR. Though most expect a high return on their investment in, at least, the form of improved healthcare quality, one of the core problems with EHRs has yet to be addressed—implementation without value.

A 2014 survey report by *Medical Economics* states, "Poor EHR usability, time consuming data entry, interference with face-to-face patient care, inefficient and less fulfilling work content, inability to exchange health information between EHR products, and degradation of clinical documentation were prominent sources of professional dissatisfaction."[1] Typically EHR vendors create solutions on a standardized platform, and customers usually implement them with limited resources, insufficient timelines, and inefficient clinical workflows—which provides further issues.

For example, the problem list requirement of meaningful use has become a problem of its own for healthcare providers due to a lack of functionality in EHR systems. Historically inpatient clinical systems have not focused on problem-oriented charting, in clear opposition to their ambulatory counterparts. And while the ambulatory systems have done a better job at focusing on the problem list as a component of the functionality they deliver, they have not addressed the issue of reconciliation of the currency or latency of diagnosis within the problem list as part of the clinical workflow, which clearly complicates diagnosis coding.

Consider the following scenario: A physician is seeing a patient in the emergency department with new shortness of breath and peripheral edema. The physician assesses the patient, orders appropriate diagnostic and therapeutic interventions, and writes an admission order based upon the medical decision making model. The physician typically composes a history and physical prior to the patient being transitioned to the inpatient unit. The EHR is designed at this point to help the physician navigate general documentation concepts of the presenting problem, and to clinically address the broad manifestations of congestive heart failure (CHF) from a diagnostic perspective. At no time does the EHR prompt the physician to add specificity to the diagnosis of CHF, nor ensure that it is added to the problem list as a new diagnosis. This gap in documentation will inevitably result in a query to the physicians if the diagnosis clarity is not present by discharge and potentially leave an important clinical documentation gap in the problem list which could impact care continuity and proper depiction of severity of illness and risk of mortality.

In this example, the physician documentation likely focused on two facets. First is ensuring that the note contains a sufficient number of body systems and components of the medical history to support the evaluation and management level. Additionally, the physician likely documented how the patient responded to the treatment and why the decision to admit them was made. Often understated is the clinical clarity of the diagnosis, as it is conveyed in the impression portion of the note. Documenting "New onset heart failure" leaves much to be clarified for the coder of this case.

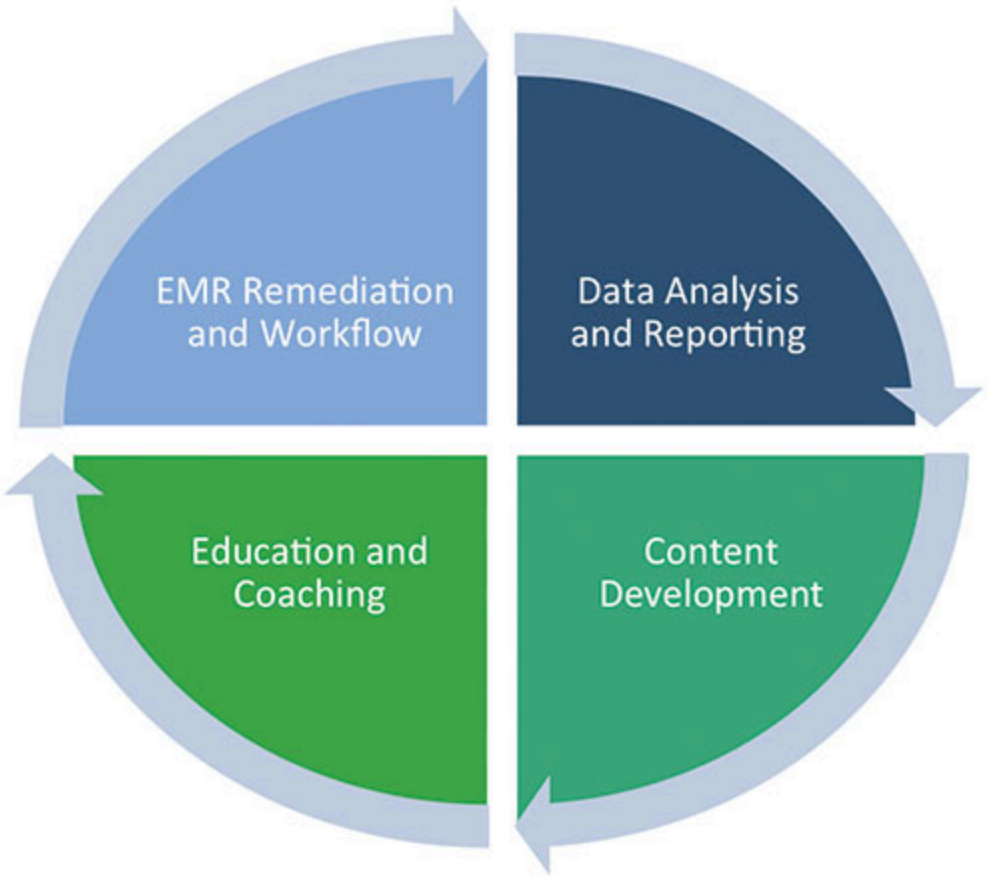
Moreover, the EHR templates created for this purpose are lacking in substantial ways to aid the clinician in bringing forth the required gap in the clinical workflow mediated by the EHR. Remediating the EHR to match the clinical workflow is a health information management professional's best opportunity to aid physicians in documenting what is required across the healthcare continuum.

Further, physician documentation is typically formatted in EHRs to support a professional reimbursement methodology where more interventions and assessment components yield greater patient acuity, as opposed to clinical clarity of comorbidities and

complications in the inpatient setting. The risks herein are great and beyond the realm of reimbursement. An incomplete or outdated problem list can adversely impact patient care.

Role of Clinical Documentation Coach

The below graphic illustrates the ongoing responsibilities of the clinical documentation coach, starting with data analysis and reporting and continuing through to EHR remediation activity.



Graphic provided by e4 Services.

Remediation Case Studies

As the EHR becomes an enabler to the longitudinal health record, clinical documentation improvement (CDI) efforts should not be limited to the inpatient setting. For one community hospital, the opportunity to improve clinical workflow was realized within the office setting and aligned with their clinical documentation approach. In this example, key physician leaders for a variety of professional offices (primary and specialty included) agreed to proceed with a pilot that included all providers from two chosen offices. Clinical documentation was reviewed, and opportunities were identified to improve both documentation and clinical workflow.

A substantial component of this data gathering exercise was the discovery of deficient mapping of clinical diagnosis-to-diagnosis codes in multiple templates. This information was not only shared with the leadership team, but a work effort ensued to remediate the templates and clinical workflow to support a more specific code selection and to update the mappings provided by the EHR vendor.

Shoulder-to-shoulder education was then offered with each of the providers in the two offices to ensure they had an opportunity to ask questions and provide input into the process. The physicians were particularly responsive to the idea that the content of the problem list is important beyond care continuity purposes, and improved quality of the problem list could help

them in risk adjusted reimbursement programs. Items to consider when developing a physician favorites/common diagnosis list would include:

- Involve a credentialed coding professional in the implementation process
- Work with the vendor during planning and design phases to clearly understand and configure provider functionality in a manner that supports documentation specificity goals
- Develop a procedure for provider usage of favorite/common diagnosis list
- Define a data quality monitoring and maintenance policy
- Ensure that body systems of greatest importance to the specialist are presented first in the user interface

The success of the pilot has drawn interest and plans are in place to continue the effort with the remaining providers across all professional offices in this organization. This effort includes EHR remediation work and a defined CDI education plan, which includes one-on-one provider education and feedback.

In another example, EHR remediation is a commitment made to physicians implementing the EHR in the ambulatory setting. The rollout required thoughtful consideration to how to avoid productivity loss and information gaps that are common to EHR implementations. To achieve this goal, the organization created a new role, the clinical documentation coach. As shown in the graph on this page, the clinical documentation coach functions as both an embedded resource within the clinical environment to coach physicians through documentation in the office setting, and also translates the clinical workflow needs of physicians into requirements for the EHR solution. This information is given to the organization's IT team who help implement the changes.

This role also reviews the aggregate data output from the compliance and internal audit findings and assesses ways that concurrent coaching, broader education, and additional EHR remediation can mitigate risk for the organization.

Clinical Documentation Oriented Across Service Lines

Another innovative approach to aligning EHR requirements with clinical workflow is to organize the CDI and coding teams around clinical service lines in an effort to coordinate all organizational efforts at improving coding and documentation in confined areas of expertise—where the clinical workflow of physicians is often unique by the specialty. In one organization, the HIM coders, CDI specialists, and performance improvement nurses all function within a single clinical service and are able to work collaboratively with physicians on how the implementation of EHR templates, including documentation clarifications, can be fashioned to support the documentation requirements for each unique setting.

A great benefit of this approach is that working with the physicians to educate them on the documentation concepts, the coding rules, and the indications for clarification has translated into opportunities to finely tune documentation in the EHR.

Strategy for Remediation Success

The HIM profession has long defined characteristics of data quality. AHIMA's Updated Data Quality Management Model describes this further stating, "The various methods of documentation in electronic health records can be unreliable for patient care if documentation guidelines and best practices are not followed. HIM professionals have intimate knowledge of these documentation guidelines and are invaluable resources when it comes to helping providers determine how they will create templates, formats, notes, and other data elements in the EHR."[2]

Industry events such as the March announcement of a delay in the ICD-10 compliance date allow the industry the opportunity to align efforts to improve clinical documentation where it originates—within the clinical workflow of the EHR.

EHR implementation and efforts related to clinical workflow design should not just be an IT project. HIM professionals bring a valuable skill set, including knowledge of rules, regulations, and standards that affect the quality of clinical documentation. Their involvement is critical to the clinical documentation and clinical workflow improvement process within and beyond the inpatient setting.

Notes

1. Verdon, Daniel R. "Physician Outcry on EHR Functionality Cost Will Shake the Health Information Technology Sector." *Medical Economics*. February 10, 2014. http://medicaleconomics.modernmedicine.com/medical-economics/news/physician-outcry-ehr-functionality-cost-will-shake-health-information-technol?page=full.
2. AHIMA. "Data Quality Management Model (updated)." *Journal of AHIMA* 83, no. 7 (July 2012): 62-67.

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