Documentation Trends in the Health Record

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The meaningful use program is well under way, helping providers and organizations adopt EHRs to capture complete and comprehensive documentation. To qualify for incentives in stage 1, organizations have adjusted their documentation processes to meet certain objectives and measures and will continue to do so as the industry moves into stage 2.

Other federal initiatives also will affect organizations' documentation processes. Implementation of ICD-10-CM/PCS will require increased specificity in documentation. The ongoing formation of state, regional, and private health information exchanges, accountable care organizations, and medical homes will require an increased understanding of metadata and its role in the documentation process.

In addition, changes in reimbursement and ongoing audits will require continued attention to documentation and how it affects revenue cycle management.

With advances in technology and various federal initiatives driving change, knowing how, where, and what to document is an unending challenge for organizations. HIM professionals must review their organizations' documentation practices and policies and procedures in order to meet these new challenges.

Documentation Options and Initiatives

"If it's not documented, it did not happen" is a phrase that has been used in HIM for many years. This phrase still holds true today and is more important than ever.

Susan Lucci, RHIT, CHPS, CMT, AHDI-F, CEO of MedScribe HIM and executive committee member of the Health Story Project (www.healthstory.com), notes that documentation must meet several goals. "Documentation should improve the quality of the patient encounter, consist of streamlined and content-rich information, include the level of specificity as needed for ICD-10-CM/PCS, and optimally enable physicians so they have the time to see a growing patient population," she says.

In order to ensure documentation is complete, many organizations are offering a variety of options to help and encourage providers to create quality documentation. Frequently, choices depend on the technology available as part of the organization's strategic direction and plan.

Options to capture required data elements can include pre-defined or custom-built templates or electronic forms with or without drop-down menus, front-end speech recognition with or without review by a medical editor, or a traditional dictation and transcription approach that may or may not include back-end speech recognition with accompanying review by a medical editor. Each option, with the exception of the traditional dictation approach, requires considerable upfront training time and commitment from the provider.

In addition many organizations are implementing clinical documentation improvement and data governance programs that focus on how data should be collected and used. These programs should ensure that documentation is clear, consistent, accurate, complete, and timely and that it satisfies stated or implied requirements for documentation of patient care.[1]

EHR Documentation Requirements

While documentation options and initiatives can often be overwhelming to implement and manage, the ultimate goal is to capture accurate and complete data for inclusion into the appropriate place within the EHR. Thought must be given to how and where the structured data element or the narrative text will be utilized in the EHR. Turnaround times can range from real-time to several hours (often depending on contractual times or departmental goals).

To this end, copy and paste is still a huge challenge in the industry, says Terri Costa, RHIA, CMT, director of HIM and quality at Betty Ford Center.

"There is potential for records to get clogged up with the same information multiple times, and there is always the inherent risk of someone copying an error and then duplicating the error throughout the chart," she says.

Costa recommends a strict copy and paste policy in conjunction with ongoing physician and staff education.

The use of e-mail and texting brings its own set of documentation challenges for HIM professionals.

While securing e-mail and text messages may be a top priority for organizations, there are other peripheral concerns, such as the use of protected health information. Organizations should outline policies and procedures and conduct staff training on the proper use of protected health information in e-mail communication between provider and patient or provider and provider.

In addition, a well-defined process must exist for archiving messages, including a documented retention policy and schedule. Consideration should be given to scenarios where changes are made to the patient's treatment plan as a result of an e-mail.

All information entered in the health record should enable triggers for workflows and alerts according to standard organizational protocol. Using copy and paste to document e-mail content in the EHR may not yield the same workflow results and places data quality at risk.

The use of texting in healthcare documentation is getting a lot of attention. According to a recent survey of College of Healthcare Information Management Executives, 97 percent of those surveyed allowed physicians to text orders to their nursing staff and 58 percent said they do not use encryption software.[2] There are privacy and security concerns within this situation due to the lack of encryption, and use of texting language in the health record carries an increased threat to documentation integrity.

Policy and procedure should address all aspects of text usage, including how text information is transcribed from the text message into the EHR with emphasis on providing complete information. Text documentation should contain professional language with no abbreviations or cryptic language for the receiver to interpret.

Clear documentation standards and proper workflows are the key to ensuring providers document information that is pertinent, timely, and accurate. It is imperative for HIM professionals to educate, implement, and monitor the data capture and documentation requirements.

Notes

1. ASTM International. ASTM E 2117-06 Standard Guide for Identification and Establishment of a Quality Assurance Program for Medical Transcription. West Conshohocken, PA.
2. Dolan, Pamela. "Physician Texting Provides Quick Communication-and an Easy Way to Violate HIPAA." October 31, 2011. www.ama-assn.org/amednews/2011/10/31/bica1031.htm.

Reference

AHIMA. "Copy Functionality Toolkit." 2008. Available in the AHIMA Body of Knowledge at www.ahima.org.

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