Perfect Time for Documentation Improvement

by Mark Hagland

When new IT systems come online, the time couldn't be better to assess and improve clinical documentation.

Electronic health record system implementations offer a perfect opportunity to assess and improve an organization's clinical documentation. The renewed attention is necessary to ensure data quality and maximize efficiencies. It also helps IT systems deliver better documentation to coding professionals.

This is particularly true for system components such as computerized physician order entry (CPOE). Ruth Ann Russo, JD, MPH, RHIT, is CEO of HP3 Healthcare Concepts, a consulting firm based in Bethlehem, PA. She stresses that automation presents the opportunity to improve clinical documentation from the outset of patient care. "There's a huge opportunity for coders to use information from computerized order entry for coding purposes," she says. "It's much simpler and, theoretically, clear-cut."

"Today, when a physician orders a drug or test, there's no requirement to actually include a diagnosis if you're on paper," notes Russo, who spent many years as a hospital coding director. "A best practice in implementing your CPOE would be to pull in your documentation requirements at the time of implementation, so that you cannot order a drug or test without a diagnosis."

Many hospital organizations are allowing physicians to sidestep that requirement, Russo points out. Organizations that create such shortcuts squander opportunities for documentation improvement and coding efficiency, she says.

There couldn't be a better moment to improve clinical documentation, agrees Kathy M. Johnson, RHIA, director of coding consulting services at Care Communications, a Chicago-based consulting agency. Transitioning to an electronic record presents a "golden opportunity…to look not just at the medium through which you deliver data, but instead to actually look at the content of that data and what you can deliver," she says. That means ensuring quality of data at every step of its creation and documentation.

It can be difficult to convey that opportunity to leadership. One of the biggest challenges for many hospital and medical group leaders, Johnson says, is "appreciating that this is more than just a process improvement effort." She points to physician office settings where doctors create free-text electronic progress notes. Working together, HIM professionals and clinicians can structure documentation formats to ensure that key elements aren't neglected in critical notes each time a doctor enters free text.

It will be extremely important for HIM professionals to be involved from the earliest phases of implementations in order to ensure that the right elements are incorporated into the new records systems, Johnson says. HIM professionals can help facilitate such processes, "because we have often been that middleman, and we have an appreciation for the structure and content needed, for standards and their value, and for how the end product will be used."

Making Improvement a Priority

At St. Luke's Hospital and Health Network in Bethlehem, PA, documentation improvement is addressed through a formal program. The health system, which encompasses a 627-bed hospital, four acute-care facilities, and a geriatric skilled nursing facility, has been live with an electronic record since July 2000, says Lynn Wall, RHIA, CCS, the health system's director of network coding services. In 2002 St. Luke's introduced a clinical documentation improvement program. Two nurses spend 90 percent of their time at the system's acute care hospitals, rounding on the hospitals' med-surg units and examining clinical documentation for cases involving all DRG-based payers.

"The process actually takes place through the coding department," Wall explains. "Our nurses round on the units, and they get a batch report nightly that comes into our department. They review that list, and for every patient who's been admitted, they'll look at their chart starting on day two. They have all the same tools the coders have," she continues. "They review the charts and look for key clinical issues." The program's nurses query physicians on the issues that arise and meet with them in person as needed.

Most queries center around the correlation of laboratory and other ancillary results with DRGs-correcting the lack of a diagnosis in a treatment order, for example-or around communication between physicians and coders. "We've been able to transcend that divide between what a coder needs documentation-wise to code and what a physician documents from a clinical perspective," Wall says.

The result is an improved process with fewer and better clinically informed queries. In addition, she says, "This is also helping the physicians from a professional fee side. We've been able to educate our staff from that side, so that they can speak intelligently with the physicians and help them document better for their purposes as well."

Wall is quick to add that CPOE has not been implemented throughout the system, a step that will doubtless afford more and broader opportunities for documentation improvement. For now, documentation remains a mixed bag, partly electronic and partly paper-based, until physician orders are automated.

Ensuring Efficiencies

Another aspect of improving documentation in health IT systems is boosting the system's usability. At San Francisco-based Catholic Healthcare West (CHW) plans are moving forward to implement full electronic records with CPOE across the system, says Gloryanne Bryant, RHIA, CCS. The 40 hospitals in the network are at various stages of advancement, but Bryant, corporate director for coding and HIM compliance, says that one lesson has already become clear: implementation offers a perfect opportunity for undertaking process improvement.

One key practical performance element she and her colleagues address is boosting system timeliness and responsiveness. In short, as Bryant says, "making sure the computer is fast enough… You don't want the coding staff regularly sitting at their PCs, 'hour-glassing' on the screen."

Ensuring sufficient speed starts in the IT selection process, Bryant says, with HIM professionals involved in every aspect of the selection process, including working with IT staff to review potential systems. Once speed and responsiveness are assured, Bryant continues, a door opens to numerous HIM improvements. Among the top ones are the facilitation of remote coding and remote auditing of coding processes. "We see productivity increase when individuals work from home, and there has been no loss of accuracy," she reports.

At Dominican Hospital in Santa Cruz, CA, Vicki Carlisle, RHIA, CHP, explains that the mechanics of the electronic system favor greater efficiency throughout the coding process. Carlisle is director of HIM and facility privacy official at Dominican, one of the many hospitals in the Catholic Healthcare West system in northern California. The latest phase in the hospital's electronic health record implementation brought with it electronic nursing documentation, laboratory and radiology results reporting, health information management, electronic signatures, and nurse order entry.

The efficiencies at Dominican begin as soon as physicians come into the hospital to see patients, Carlisle says. They are provided with an opened electronic inbox (also available remotely), which contains documents requiring approval and signature. The system allows the physician to make modifications and corrections to the record before the document is sent on to other appropriate physicians and then to HIM. The software allows coders to easily query physicians.

With CPOE scheduled to go online this summer, Carlisle and her colleagues prepared for additional innovations. Ultimately, she says, the trajectory of this path points to computer-assisted coding, with coders working more as editors than as initial compilers of data. As editors, they will be responsible for the review, editing, and validation or correction of clinical information. Not surprisingly, she sees coding professionals becoming coding mentors to physicians, once that more advanced stage is reached.

A Broad Consensus on Benefits

Physicians aware of clinical documentation issues tend to agree that there are mutual benefits in improving documentation. Ronald L. Hirsch, MD, is a general internist and a partner in Signature Medical Associates, an eight-doctor primary care practice in Elgin, IL. He looks forward to CPOE implementation at nearby Sherman Hospital, where he is head of medical informatics. The hospital currently has a fully implemented electronic record.

Sherman Hospital has an ongoing coding documentation initiative in place, one that is helping physicians code more specifically in order to catch all associated comorbidities-"to document, for example, chronic kidney disease instead of renal insufficiency," Hirsch explains. Hirsch sees the broader care and documentation process improving generally when CPOE is introduced.

"Right now," he notes, "I can go into the system and see the patient's vital signs, but I can't see the progress note from the specialist since I last rounded." In the future, in a CPOE-facilitated environment, he says, "If a patient is vulnerable to kidney failure, the system will generate a code for that, and it will allow the coders to do their job much more easily."

Johnson of HP3 offers four pieces of advice for successful electronic document improvement efforts. She advises healthcare organizations develop strong, collaborative relationships with their software vendors. This is essential in getting information systems that will make clinical documentation improvement possible, she says. That same collaborative approach among HIM, IT, and clinicians-throughout the entire implementation process-is equally important.

Johnson also stresses that workflow optimization should accompany automation. Finally, organizations should seek buy-in from all end-user groups on a system with the most structured content possible and acceptable to all groups. "Many people try to do this without structuring because it seems easy and painless, but then it's not as effective or useful," she says. "It's much like a car design: you have to keep in mind who the driver is. And the driver for the electronic health record is the physician."

In the end, increased patient safety, improved quality of care, and greater efficiency result when the right elements are brought into the mix. As Dominican's Carlisle says, "If we can optimize documentation, we can have a higher quality of data in healthcare. That was really what coding was about years ago, before DRGs came along. The emphasis has been on reimbursement, but better coding can help produce better quality in healthcare."

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