Recognizing the Characteristics of Quality Documentation

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When we take a bite of our favorite food we can easily determine the quality by relying on what our senses tell us. The look, smell, and taste are all clues to the quality that was put into preparing the meal. If it looks undercooked or has mold on it, smells foul or tastes bitter, we know right away we should not eat it.

In healthcare, providers and consumers need more than the five senses to recognize the quality of care delivered by a provider. In many cases, it's difficult to judge the quality of care until an episode has been completed and outcomes can be measured. Providers rely on reporting agencies to pull together the outcome data and display the results in reports to determine which providers deliver the highest quality of care.

Quality reporting agencies can only report out diagnoses that have been documented within the medical record. It is important for physicians to provide high-quality clinical documentation to reflect a complete picture of all diagnoses and care provided. The diagnoses are then translated into alphanumeric codes called the International Classification of Diseases (ICD) that can be used in a variety of ways to measure the quality of care.

It is easy to see why high-quality documentation is important in quality reporting. Unfortunately, this process can become frustrating for physicians whose medical education was focused on delivering high-quality care, but did not include education on high-quality documentation. Clinical documentation improvement (CDI) specialists are a resource to which many providers are turning to make sure their documentation reflects the high quality of care they are providing.

Even providers with the most comprehensive plans to learn documentation requirements can become frustrated. The demands of patient care leave little time for additional education. The statement "I just want to take care of my patients" often echoes through hospital halls. This article examines the characteristics of high-quality clinical documentation discussed in Pamela Hess's book *Clinical Documentation Improvement: Principles and Practice.*

Fostering High Quality Clinical Documentation

By applying seven characteristics to clinical documentation, as described in Hess's book, physicians will have the foundation needed to be successful. The seven characteristics include documentation that is legible, reliable, precise, complete, consistent, clear, and timely.[1]

The description of each characteristic is listed below:

- **Legible:** With the transition into electronic health records (EHRs), readability of clinical notes is becoming less of a problem. However, there are still some hybrid records that have handwritten notes. No matter the type of record, documentation should be easy to decipher and comprehend.
- **Reliable:** The documentation should be trustworthy. Take the case of a patient who is admitted with a GI bleed and is given a blood transfusion. The treatment suggests there is something in addition to the GI bleed that required the blood transfusion, such as acute blood loss anemia due to the GI bleed. If the diagnosis of acute blood loss anemia is present but isn't documented, then the result is missing diagnostic information. Thus the other caregivers and the patients cannot rely on the physician's documentation to represent all of the current conditions.
- **Precise:** The documentation should adhere to strict definitions of medical terminology, and be as accurate and exact as possible. An example Hess offers is a patient who has a chest X-ray that shows aspiration pneumonia. The doctor only documents pneumonia and does not address the finding of aspiration pneumonia. Failure to achieve the highest level of precision could have a negative impact on treatment, follow up, and reimbursement. If the primary care provider reads the hospital documentation and determines the patient only had simple pneumonia instead of aspiration pneumonia, the

treatment and follow up plan may be impacted. In the example above the reimbursement will be inaccurate if the diagnosis was not precise enough to assign the appropriate DRG.

- **Complete:** The documentation should contain every detail that might be important to caregivers, the billing department, and even the patient, down the line. Hess uses the example of abnormal lab findings and notes that the significance of these findings should be documented within the record. For example, if a finding of low potassium is noted, the caregiver needs to specify whether this should be identified as hypokalemia or as a finding with no clinical significance.
- **Consistent:** The documentation should be consistent throughout the record. Attending notes and consulting notes should not contradict each other. It is important to look at the details of each provider note to see a consistent theme develop during the stay.
- **Clear:** The documentation should describe everything that is being treated to the highest level of specificity. An example would be when a patient comes into the hospital with a symptom such as chest pain and the etiology is not documented. This doesn't paint a clear picture of the care provided. Did the provider try to determine the cause of the chest pain? Even if the etiology is unknown, that would need to be documented to give a clear picture of the plan of care.
- **Timely:** Timely documentation is critical to deliver the best care to the patient. An example is a condition that isn't documented until day three of a patient's stay. That condition may not be considered present on admission and therefore will look like a hospital-acquired condition. If the hospital has a diagnosis that is reported as a hospital-acquired condition, they will deny reimbursement.

CDI Specialists' Role Vital for Quality

CDI programs are becoming increasingly popular for providers. A CDI specialist is an expert in documentation requirements and usually has a background in nursing or diagnosis coding. They review medical records for the level of specificity needed to support high quality clinical documentation. If they identify a gap in the documentation they will send a query to the provider to see if further specificity can be provided. Many CDI specialists review the record concurrently with the patient stay to support timely documentation. The CDI specialist also provides ongoing education to providers on updates and trends seen in clinical documentation.

The typical CDI program is seen in the inpatient setting, though some programs are now looking at ways to incorporate CDI into the outpatient setting as well. CDI in the outpatient setting would require a different structure than the inpatient setting. In the inpatient setting the patients may be admitted for several days, giving CDI time to review the record concurrently. In the outpatient setting the patient's care is provided within a shorter time frame. A process would need to be developed to review the records as close to the time of care as possible. The CDI specialists working in the outpatient setting will need to become aware of the outpatient quality reporting and payments systems.

Quality Measurements Part of Payments

Measuring the quality of care is becoming a major focus within the world of healthcare. Healthcare payers are shifting away from paying for services to paying for quality. The Centers for Medicare and Medicaid Services (CMS) is leading this effort and has developed quality measures that cover both inpatient and outpatient settings. They use these measures to publicly report the scores for hospitals and physicians so the public can easily compare them and choose where they want to go for care. The websites that publish this data for public use are Hospital Compare and Physician Compare. The complexity of the metrics used is far too vast to cover each component in this article. Some examples of the data that is provided on these sites include: [2]

Hospital Compare

- Timely and effective care
- Readmissions and deaths
- Surgical complications
- Use of medical imaging
- Patient experience

Physician Compare

- Services delivered
- Quality ratings
- Medical school education
- Group profile
- Hospital affiliation

For more information on the Hospital Compare and Physician Compare quality websites, visit CMS' website at www.CMS.gov.

Notes

[1] Hess, Pamela C. *Clinical Documentation Improvement: Principles and Practice*. Chicago, IL: AHIMA Press, 2015, p. 9-10.

[2] Centers for Medicare and Medicaid Services. "Hospital Quality Initiative." April 10, 2013. www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/index.html.

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