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### **Clinical Documentation Improvement: Quality Information Through Quality Data**

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**Leslie:** This month I would like to focus our discussion on clinical documentation improvement. We have heard a lot of buzz as they say in the marketing world about the opportunity to leverage electronic health records (EHRs) to improve clinical documentation. The EHR offers an opportunity to “design-in” documentation requirements thereby ensuring that the documentation captured represents care provided and the quality of that care.

**Patty:** The buzz is well founded. The need to ensure that an organization’s clinical documentation accurately reflects the care provided has become top of mind for senior leaders. An organization’s coded data communicates to consumers the organization’s quality, experience and overall outcomes. An organization’s data is now publicly available for consumers to use as they shop for health care services.

**Leslie:** Let’s talk with Rita Scichilone, the American Health Information Management Association’s (AHIMA) director of professional practice resources. She has quite a passion for the topic of clinical documentation improvement and can help us and our readers better understand the current landscape.

**Patty:** Hi Rita. Thank you for spending time with us this month discussing clinical documentation improvement. Let’s start off by defining clinical documentation improvement.

**Rita:** There is really no official definition I am aware of, but I think of clinical documentation improvement as a performance assessment and improvement program. The focus of the program is on clinical data capture and transforming it into the record of health care service encounters. Clinical documentation improvement programs focus on deficiencies and finding methods to ensure the complete and useful storage of important clinical facts.

These facts form the basis for additional clinical data usage after the service is rendered.

**Patty:** That sounds very complex Rita.

**Rita:** It all comes down to making sure that an organization’s data capture processes result in the ability to describe the essence of an encounter. It is also important to ensure that secondary data is accurate for the myriad of required and voluntary reporting and decision support.

**Leslie:** Rita, how do coding leaders leverage EHRs to improve clinical documentation?

**Rita:** Coding leaders can influence the intelligent design of EHRs. There are at least three ways in which coding leaders can have input into the design of systems: They can ensure that systems are designed to incorporate compliance and legal requirements; participate in the simplification and ease of data input methods; and take

advantage of software and system tools to automate required data abstraction such as collecting data quality indicators.

**Leslie:** What are some examples of methods that simplify data input?

**Rita:** These would be methods such as checklists, drop down menus, templates and the use of imbedded controlled terminology systems.

**Patty:** What do you mean by “imbedded controlled terminology systems?”

**Rita:** I think of these as data structures in the black box where terminology used to describe observations, test results and events is transformed into meaningful clinical data. The black box is like “Intel inside” your computer. You don’t necessarily know how it works but you know it captures, stores and processes data. The black box of imbedded controlled terminology systems translates text into a language computers understand. It takes the expressions of a physician’s words and stores it in a way that determines how to display it and use it for a specified purpose. A SNOMED-CT® (Clinical Terms) code for example is a numeric string that has a very distinct meaning to a computer but is meaningless to human beings. SNOMED-CT is designed for use in software applications such as EHRs.

**Patty:** That’s a great analogy. The ability to take a physician’s spoken word and translate it into meaningful clinical documentation and data that can be queried will completely transform the way we collect, code, use and report clinical data. Imbedded terminologies can transform the way HIM professionals lead their organizations toward the achievement of quality information through quality data.

**Leslie:** Rita, how does one create urgency in their organization about clinical documentation improvement?

**Rita:** Urgency already exists. It comes down to dollars and cents. Good documentation is good business. Health records are the currency that flows through any organization that provides patient care. If inadequate, incomplete or incorrect, the organization will have performance problems in both clinical and financial performance and may not meet customer satisfaction targets.

**Patty:** It’s good to hear that urgency on this issue is up in organizations. But what if it isn’t? What should an HIM professional do?

**Rita:** It’s pretty easy to create urgency by illustrating the inability of an organization to be its best when its documentation practices don’t capture the details of encounters that ultimately enrich clinical decision support and assure accurate reporting for reimbursement and other external data reporting needs.

**Leslie:** Do physicians have urgency over clinical documentation improvement?

**Rita:** Physicians are supportive of clinical documentation improvement efforts provided the program is designed in such a way that it doesn’t cut into their time spent on patient care activities. We need to be creative and think of ways to make physicians’ lives easier and implement initiatives that provide value to them and enhance the practice of medicine. The program can’t be yet another exhausting demand made on them in the workplace. For example, be specific. Tell physicians exactly what is needed and make it easy for them to comply. The goal is to understand the thought flow of a physician. Design documentation input with this in mind and the result is good documentation that becomes second nature to a physician over time.

**Leslie:** Designing data capture methods is one way coding leaders can really help simplify the documentation process yet ensure compliance with regulatory requirements. What a great opportunity for coding leaders to

make a difference in the quality of an organization's data.

**Patty:** Who are the key players in the document improvement process and what are their roles?

**Rita:** There are a number of players and I group them into three major categories: providers of health services, which includes physicians, nurses and therapists; infrastructure staff, such as information technology, business or financial services, HIM and case management; and the consumer.

**Leslie:** I love that you include the consumer as a key player. Speaking for a moment as a consumer, I know that as we move to more consumer-driven health care models, we are expected to take more and more responsibility for our health care. Participating in assuring the accuracy and completeness of documentation of that health care makes a lot of sense.

**Rita:** That's right Leslie. We can't forget about the patient. Well designed input tools completed by consumers before or during the health care encounter also improve the health record by enhancing the quality and completeness of the entries.

**Patty:** What can the front line coders do from their seat to help with clinical documentation improvements?

**Rita:** Coders play a very important role by serving as a resource for communicating what information is required to assign codes to the highest degree of specificity and complete the most accurate picture on claims for health plans and other secondary data users. They can also contribute to the development of formats that facilitate details required for coding at the point of care, so that queries to physicians post-service are limited.

**Patty:** How can coders get more involved?

**Rita:** They need to step up to the plate and volunteer to help educate the organization. They can put together an educational piece on a particular documentation issue for example or hold a round table discussion. They can also participate in the development of a documentation handbook for physicians that outlines basic documentation requirements.

**Patty:** What is typically included in a basic handbook?

**Rita:** It would include documentation required for a history and physical, operative note and discharge summary for example. It's rewarding to put this together as a department or team and then present it to the chief of the medical staff for review and feedback. Once you have incorporated comments and received approval of the documentation handbook, it would then be presented to the medical staff and perhaps incorporated into the medical staff rules and regulations. You have to start somewhere, and a basic handbook spells out the fundamentals and creates a foundation for all documentation improvement programs.

**Patty:** What about the coding leader? What is their role?

**Rita:** They are the cheerleaders, educators, translators and connectors. Their role primarily includes:

- Encouraging coding professionals to be life long learners;
- Teaching staff and users of coded data about the context requirements of the code sets, why official guidelines and coding conventions are critical to data integrity;
- Translating coder-speak to clinician friendly language; and
- Connecting coders with both the source and users of their work product.

**Patty:** How does one sustain clinical documentation improvement?

**Rita:** Today's health care system demands a less costly, more efficient method of moving information from place to place while mandating more detail and specificity in the records. Health information managers are uniquely qualified to utilize technology and find better documentation capture and storage techniques, to balance the need for data with the value of saving clinician time.

**Leslie:** What do you think the impact of quality indicators will be on documentation improvement?

**Rita:** Health care plans are going to be looking at those quality indicators when making reimbursement decisions. This is also an area in which coding leaders can help significantly by ensuring that the EHR captures quality indicators real time so we can avoid the need to abstract these indicators retrospectively like we do today. In fact, so many quality indicators are being proposed that it could take a significant amount of time to code and abstract an encounter using a traditional system. It will be paramount that quality measures are captured as part of the day-to-day clinical workflow process, and incorporating technology tools to automate the process will make it more efficient.

**Patty:** What are AHIMA's activities around clinical documentation improvement?

**Rita:** AHIMA continues to foster best practices and educational resources that assist our members in helping their organizations solve documentation deficiency problems. AHIMA is currently updating the Quality Healthcare Data and Information Position Statement. In addition, an e-HIM® work group will be working on Guidelines for Electronic Health Records Documentation Practices: Best Practices for Fraud Prevention this fall.

**Patty:** What is the focus of these guidelines?

**Rita:** With all the automation of content and its intersection with coding, we need some deep thinking on how to ensure integrity and prevent the manufacturing of data that may not reflect the truth. We have guidelines for the legal record and now need guidelines related to integrity management as organizations and software developers set out to build templates, and design other data capture tools that populate and comprise the record.

**Leslie:** What are some resources for coding leaders working on clinical documentation improvement initiatives?

**Rita:** I recommend joining the AHIMA Community of Practice (CoP) for Documentation Improvement, Data Management or other CoPs that feature a wealth of information and ideas from experienced professionals. You can find invaluable resources on the CoPs from checklists for complete documentation to opportunities to view the draft version of the Quality Healthcare Data and Information Position Statement.

**Patty:** The community discussions are also rich with content and sharing.

**Leslie:** Thank you Rita for a very interesting conversation. We appreciate your passion and sharing your expertise on this topic. You have painted an exciting role for coding professionals and a future that gets us closer to achieving quality information through quality data.

*Leslie Ann Fox is chief executive officer and Patty Thierry Sheridan is president of Care Communications Inc., a national HIM consulting and staffing company headquartered in Chicago. They invite readers to send their thoughts and opinions on this column to [lfox@care-communications.com](mailto:lfox@care-communications.com) or [pthierry@care-communications.com](mailto:pthierry@care-communications.com).*