Success Strategies Associated With Bridging Clinical Documentation Gaps in the Electronic Record

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Session Outline

I. Ensuring that the record tells the patient's story
II. Research performed associated with clinical content integrity to serve as the business case for launching an improvement effort
III. Building the business case and engaging physicians in improving their documentation practices
IV. Case examples of successful interventional methods: education, technology, communication, and feedback to bridge the documentation divide
V. Best practice guidance associated with the clinical content redesign, oversight and auditing, and effective feedback mechanism to ensure key performance indicators are met and maintained
Learning Objectives

- At the completion of this educational activity, learners will be able to:
  - Identify the hazards of "note bloat" and “copy and paste” in the EHR as substantiated by research
  - Describe how documentation templates in the EHR can be designed to support care, treatment, diagnosis and procedural capture, and assure that quality initiatives and meaningful use measures are attained
  - Utilize prevention strategies to reduce unnecessary content and unreadable notes

What Is Your Greatest Obstacle in Ensuring Documentation Integrity?

1. The hybrid state of our electronic record – makes it difficult to identify the source of the final documentation
2. We do not have a way to lock down our electronic system, and corrections and amendments can happen at any time
3. The quality of our documentation has eroded since we transitioned to the electronic record
4. Cloned documentation is concerning
5. The problem list is neglected, not filled out completely or accurately
And We Thought EHRs Would Solve Our Documentation Integrity Woes

*Those who are authorized to document within the EHR are accountable for every EHR entry made, including errors*

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What Are the Initiatives We Need to Care and Feed?

- Core measures
- Present on admission
- Pay-for-performance
- Meaningful use
- ACO and healthcare reform initiative requiring *big* data
- ICD-10
Barriers to MD Participation

- Loss of autonomy
  - MD can no longer document using traditional means
  - Documentation is being challenged externally
- Fear of change
  - MD inability to change or effectively grasp concept of CDI/ICD-10
  - May hinder patient care
  - Older physicians may not possess the computer skills
- Loss of time in patient interaction
  - Emphasis on mechanics of coding and terminology diverts attention away from patient-centered activities
MD Perception of Goals of the Program – Impacts Acceptance

Goals of documentation in the EHR:

<table>
<thead>
<tr>
<th>MDs</th>
<th>Hospital administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Accurate characterization of patients</td>
<td>• Improve accuracy of coding</td>
</tr>
<tr>
<td>• Choice of documentation tools</td>
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<tr>
<td></td>
<td>• Improve severity &amp; case mix</td>
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<td></td>
<td>• Improved data capture for compliance purposes</td>
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<tr>
<td>• Coherent synthesis of a sequence of</td>
<td></td>
</tr>
<tr>
<td>clinical events</td>
<td></td>
</tr>
<tr>
<td>• More reliable medical records</td>
<td>• Quality measure of outcomes for external regulatory</td>
</tr>
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<td></td>
<td>agencies, ACO participation, and compliance with</td>
</tr>
<tr>
<td></td>
<td>meaningful use</td>
</tr>
<tr>
<td>• Effective communication of clinical</td>
<td></td>
</tr>
<tr>
<td>issues between specialties</td>
<td></td>
</tr>
<tr>
<td>• Continuity of care</td>
<td></td>
</tr>
</tbody>
</table>

The Challenges and Dependencies

People
• Physicians, midlevel providers, and clinicians

Process
• Structured e-documentation requires many clicks, typing, or voice recognition
• Many documentation tasks are rooted in the paper process
• Double documentation is common
The Challenges and Dependencies

Culture
• Time consuming CPOE and medication reconciliation
• Slows me down more

Technology
• Requires training, unlike traditional transcription or pen and paper

Current State of EHR Documentation
• Automated linked templates have often been created and used to gather data from the electronic chart into a structured note:
  – Laboratory results
  – Active medication lists
  – Allergies
  – Problem lists

Use often leads to note bloat

“The hospital computer system has a virus. Ironic, isn’t it?”
Balanced Approach Though ...

So What’s the Big Deal?
It Works for Us!
Has Any Research Been Done on Copy Paste Functionality (CPF)?

- According to O’Donnell, et al., 1 90% who use EHR routinely use CPF:
  - 70% used CPF in writing progress notes
  - 71% noted inconsistencies and outdated information were more common in copy-and-pasted notes
  - 19% felt that CPF had a negative impact on MD documentation
  - 24% felt it led to mistakes in patient care
  - 80% wanted to continue to use CPF


Risks Identified in Research of CPF

- Embi, et al., 2 performed a small study interviewing VA residents and faculty identifying:
  - **Redundancy**: same information and misinformation repeated over and over again – difficult to identify where the misinformation begins
  - **Formatting**: difficulty segregating out the useful information and “stuff you care about” from the endless notes
  - **Decreased confidence in the material**: “… the same physical exam as the intern’s, resident’s, attending’s, and in subsequent sub-specialists’ progress notes”

If We Can’t Beat the Habit – Are There Some Industry Best Practices?

- Hammond, et al., concluded that disabling CPF would have a crippling effect on electronic documentation and, instead, recommended an approach of:
  - User education
  - Enunciation of strong guidelines
  - Effective monitoring systems and supervisory feedback

Recommendations to Mitigate Risk

- Hammond et al. further proposed that institutions using EHRs consider:
  - Reengineering templates to avoid unnecessary duplication artifacts
  - Minimizing the insertion of patient data available elsewhere into the narrative record
  - Developing medical history and examination data objects that can be reviewed, amended, and reused
  - Enhancing the problem list function as a better alternative to copying text lists

Recommendations to Mitigate Risk (cont.)

• Hammond et al. further proposed that institutions using EHRs consider:
  – Enhancing automated methods to more efficiently monitor for dangerous and misleading copying
  – Cautioning clinical departments against excessive use of copying to boost productivity
  – Teaching practitioners and students that careless copying creates untrustworthy records
  – Empowering teachers to monitor the writings of trainees with automated methods

Don’t Forget About Regulatory, Accreditation, and Payer Requirements

And remember:
The individual performing the copy/paste is responsible for the documentation regardless of who authored the original information!
Data Integrity – the Medicare Conditions of Participation

There must be a method of determining that the practitioner did, in fact, authenticate the entry after it was created

- Where an electronic medical record is in use, the hospital must demonstrate how it prevents alterations of record entries after they have been authenticated (Interpretive Guidelines)

"The last person who went into medical records has still not been found."

Turn to the AHIMA Copy Paste Toolkit for Guidance

Education of the documentation integrity risks:
Inaccurate, inconsistent, repetitious, and/or outdated information adversely impacting:
- Patient care
- Identification of the date the documentation was created
- Identification of the author for each entry
- Identification or defense of E/M codes for professional or technical billing
- Propagation of false information

Best practice tips:
- Auditing
- Documentation integrity
Barriers to Effectively Meeting EHR Clinical Documentation Best Practices

Compliance Risk Areas to Be Mindful of With Clinical Documentation in EHRs

- Source system feeds and interfaces
- Change management controls and processes for system changes
- System upgrades, data loads, configuration, security settings or role-based access permissions
- Hybrid records (paper and one or more electronic applications)
- Interface and maintenance issues for organizations with multiple EHR module
Compliance Risks: Clinical Applications

• Chart documentation (data integrity and authentication)
  – Who documents what?
    ▪ Copy and paste from previous encounter or different chart
    ▪ Residents and midlevel practitioners proof of supervision
  – Encounter documentation and completion
  – Encounter closure logic (what data or information is required to close an encounter?)
  – Coding and billing for closed encounters only
  – Electronic signatures, author attribution, and authentication of data

Compliance Risks: Ambulatory or Clinic Documentation

• Encounter closure and completion of documentation
• Timely encounter documentation completion
• Diagnosis-order association (medical necessity)
• Electronic signatures
• Configuration of non-face-to-face encounters
• Email or virtual encounters
• Retaining patient-centric communications
  – Telephone encounters
  – “Orders only” encounters
Design Considerations in Provider Documentation
System Redesign

Where Do You Start?

Find all systems – all media
• Conduct a source system review
• Where, who, what – output?
• Governance
• Education
Organizational Design Strategies for Your Consideration

- Are there alternatives to the use of copy functionality?
- How will we ensure user competency?
- What copy functionality exists within the EHR – including the ability to make corrections?
- What will be our process to mitigate and identify unacceptable use?
- Who is going to enforce the policies?

Design Strategies for Your Consideration

- Does the system allow for “soft” copy forward?
- How are chart errors identified and corrected?
- What audit trails are available?
- How is reauthenticated information identified?
- How are source documents identified?
- Is copied information easily identified?
- Are the document versions viewable and accessible?
- Are permissions granular enough to associate role with function?
Develop an Operational Strategy for Data Replication Reduction

- Investigation/troubleshooting
  - Consider data integrity coordinator position – to oversee and manage EHR record integrity functions, including chart corrections
- Auditing and reporting
  - Fold into existing functions (CDI, coding, analysis, and/or closed record review)
  - Report and address significant issues through governance structure, following review by MD champion
- Carefully review all record sets BEFORE you release them
- Have proper notification policies and procedures in effect

Develop an Operational Strategy for Clinical Documentation Integrity

Operational leadership:
HIM/CDI professionals in collaboration should provide the leadership to oversee and ensure quality, timely and accurate documentation, and sufficient knowledge of system capabilities to manage clinical documentation integrity
Ways to Mitigate Risks to Ensure Optimal Record State

Current State to Future State

**Paper:**
Medical record comm.
- Paper – hybrid

Forms comm.
- Report to HIM
- Chaired by HIM
- Focus:
  - Regulatory/legal
  - Efficiency
  - Communication
  - Document

**Electronic:**
EHR governance
- Managed regardless of media

Clinical content/data integrity workgroup:
- Cochaired: HIM/CMIO
- Focus:
  - Regulatory/legal
  - View appropriate to role
  - Consistency
  - Confidentiality
Form e-Record Content Committee – Interdisciplinary Approach

- To provide a forum for strategic planning
- To prioritize and coordinate changes
- To oversee the use of clinical decision support
- To oversee the development of clinical documentation and template development and management, including all forms
- To oversee the legal medical record definition, policy, practice, and compliance

Standardization Decisions

- Chart order in EHR
- Chart review
- Patient headers
- Access
- Research considerations
- Confidentiality
- Quick disclosure/printing
- Transcription – speech recognition strategy
- Documentation templates
- Chart corrections/moves/amendments/addendum/pended notes
- Patient identity/EMPI oversight
- Copy/paste
Setting a Documentation Standard Is Key

- If the discrete data is somewhere else in the electronic health record, the provider should not have to duplicate the information.
- Document once – reuse if essential to populate a required field or necessary for downstream reporting requirements.

Avoid duplicating documentation in templates, dictations, or other narrative forms of documentation.

Strategy for the Reduction of Data Replication and CPF

- Past medical history – can be carefully copied forward from a previous hospitalization (not from another patient), but not the review of systems, plan of care, medications, allergies.
- Structured text, by diagnosis, to facilitate documentation is carefully designed and utilized to reduce the need for CPF.
- HIM and CDI team should be involved in template design in team to ensure optimal content.
- Copy functionality is carefully evaluated and utilization if optimal for workflow efficiency and if risk is mitigated, e.g., flow sheets.
Strategy for the Reduction of Data Replication and CPF

- Reconfigure the forms committee to deal with EHR content, format, accessibility, and structure
- Closed record review can be utilized as another forum to audit record integrity
- Ensure that each entry is signed, dated, and timed by the author of the note
- Ensure that the workflow includes an attending MD note prior to the closing of an ambulatory encounter
- Use caution when utilizing functionality that enables an attending to take over the notes of midlevel providers to ensure that the original author is maintained

- Beware of “pended” notes or “notes in progress” where an MD is interrupted – make sure that these are finalized
- Record analysts and coders – are on the lookout to review for documentation discrepancies
- Consider using front-end speech recognition and partial dictation for complex patients’ PMI and review of present symptoms
- Involve your CMIO and medical staff leadership
How Do We Engage the Stakeholders?

Why Is Clinical Documentation and Integrity Important?

- Improved quality of care
- Correct, complete, accurate documentation impacts patients, physicians, and institution
- All clinicians are responsible for documenting the treatment and outcomes of the patient
- Documentation is used for clinical research and education
- Supports diagnoses and procedures that were billed
- Impacts reimbursement
- Compliance with CMS regulations
- Preparation for ICD-10
Impact of Clinical Documentation

<table>
<thead>
<tr>
<th>Patient</th>
<th>Physician</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Quality of care provided</td>
<td>• Demonstrates accountability</td>
<td>• Coding and billing</td>
</tr>
<tr>
<td>• Continuity of care</td>
<td>• Performance management</td>
<td>• Supporting documentation for treatment and services rendered</td>
</tr>
<tr>
<td>• Non-payment by insurance for illegible condition or treatment</td>
<td>• Reduced or denied payment</td>
<td>• Appropriate reimbursement</td>
</tr>
</tbody>
</table>

10 Steps to Engage Physicians Now

Providing the electronic clinical documentation necessary to support care, treatment, and data integrity:

1. Assess current clinical documentation workflow
2. Outline the future state: who, what, and where
3. Coding and documentation gap analysis impact analysis
4. Develop the marketing and communication plan
5. Prepare the training plan
6. Identify strategies, solutions, and/or refinements
7. Develop the budget
8. Prepare transition road map
9. Implement documentation improvement program
10. Refine reporting metrics
**Step 1: Assess Current State of Workflow**

- What are the present choices for the provider to capture the patient’s diagnoses and document the care and treatment?
  - Problem list – SNOMED CT – terminology to ICD-9-CM?
  - Pick list
  - Free text?
  - Dictation/speech recognition
  - Direct entry into EHR template
  - Combination of approaches
- Evaluate provider satisfaction with current state and bridge strategies associated with the development road map

**Step 2: Outline Future State of Workflow**

- Understand how/where to determine the critical components of the MD workflow to improve clinical documentation, coding, reporting, and charge capture
- Identifying key items to address now to prepare for a successful implementation
- Repurpose activity to care and feed other initiatives: meaningful use, ACO, quality reporting
- Identify the key players who are necessary to support the transition
Step 3: Documentation Impact Analysis

- Conduct an in-depth chart analysis of a representative sample of records to identify clinical documentation integrity challenges:
  - Determine if documentation is missing, inaccurate, misleading, or incomplete
  - Identify the source of the documentation and technology and/or documentation work streams
  - Identify template artifact which could be construed as cloned or could lead to lack of compliant updates at the time the patient is being seen
  - Identify if documentation has been cut and/or pasted from another encounter

Develop a Road Map to Address

- Technical requirements
- Systems remediation
- Business process redesign opportunities
- Physician engagement and education
- Budgetary estimate for the capital and operating costs associated with improving clinical content capture and data integrity
Identify Where to Target Improvement

Gap Analysis – Clinical Documentation Integrity Review Scope

Concurrent review:
• Leverage your CDI team as your eyes and ears to identify:
  – Non-original, outdated, irrelevant, useless content
  – Problem list entries, unrelated to current hospital problems
  – Erroneous entries

Retrospective review:
• Leverage your HIM team data integrity and coders as your eyes and ears to identify:
  – All of the above issues, plus issues with dictated notes and final discharge summaries with outdated, irrelevant, useless, or erroneous content
Clinical Documentation Improvement Practices

• Evaluate the detail and quality of documentation
• Implement and monitor documentation improvement strategies
• Assess vendor-supported documentation tools

Step 4: Marketing and Communication Plan for Physicians

• Keep the message and marketing simple, direct, physician focused
• Develop testimonials to enlist and engage physician involvement
• Make it meaningful, relevant, and integrated
• Demonstrate early results from improved clinical documentation improvement capture
• Use the power of data to demonstrate return
**Step 5: Prepare for Physician Training**

- Discuss which training methodology, format, structure, venue works best for each provider/specialty
- Identify physician champions
  - Training approach
  - How to leverage them to support the process and lead by example
- How to structure training for maximum participation and impact
  - Initial awareness training
  - Specialty specific
  - Clinical documentation improvement
  - Tools to facilitate documentation
  - Feedback/peer comparative analysis

**Physician Training Specifics**

- Who needs to be trained and when?
- Can you incorporate the training into other required education, ICD-10, meaningful use?
- Determine timing of the training?
- Begin training on documentation gaps and compliance risks
- Keep the message clear
- Must be specialty specific
Step 6: Identify Technology Approach and Other Key Strategies

- Overall impact of poor documentation and template design and documentation that detracts from the meaningful content of the EHR initiative with downstream implications
- General impact of coding and documentation changes to:
  - Current reports/trending involving data integrity
  - Additional quality efforts needed to ensure proper documentation specificity
- Review opportunities that could impact reimbursement, value-based purchasing, and pay-for-performance
- Identify benefits of implementation
- Create a timeline

Step 6: Identify Technology Approach and Other Key Strategies

- Evaluate current technology
  - What is included with EHR
  - Niche systems to facilitate clinical capture
- Is there a way to improve current technology to improve efficiency?
  - Opportunities to repurpose data
  - Mapping of terminology to classification
**Step 7: Estimate Budgetary Requirements for Organization**

- Include all costs associated with physician implementation, including:
  - Software
  - Hardware procurement
  - Salaries of MD champions, CDI staff
  - Implementation/deployment
  - Possible EMR upgrade or new implementation
  - Physician training
    - Coding staff – to provide examples from chart reviews
    - CDI staff – to participate, support, and provide examples
    - Physicians
    - Administrative staff
  - Cost due to workflow process changes and testing
- Communicate budget plans with senior management or decision-makers
- Develop an ongoing budget reassessment process

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**Impact Assessment Inventory**

<table>
<thead>
<tr>
<th>Billing Financial</th>
<th>Reporting</th>
<th>Clinical systems</th>
<th>Registration</th>
<th>Support systems</th>
<th>HIM</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG grouper</td>
<td>Provider profiling</td>
<td>Clinical protocols</td>
<td>Registration &amp; scheduling</td>
<td>Case-mix systems</td>
<td>DRG grouper</td>
</tr>
<tr>
<td>Conversion of other payment methodologies</td>
<td>Quality management</td>
<td>Physician order entry systems</td>
<td>Advance beneficiary software</td>
<td>Utilization management</td>
<td>Encoding software</td>
</tr>
<tr>
<td>National and local coverage determinations</td>
<td>Utilization management</td>
<td>Clinical reminder systems</td>
<td>Performance measurement systems</td>
<td>Quality management</td>
<td>Abstract systems</td>
</tr>
<tr>
<td>System logic and edits financial systems</td>
<td>Disease management</td>
<td>Medical necessity software</td>
<td>Medical necessity edits</td>
<td>Case management</td>
<td>Compliance software</td>
</tr>
<tr>
<td>Claim submission systems</td>
<td>Registries</td>
<td>Disease management systems</td>
<td></td>
<td></td>
<td>Abstracting</td>
</tr>
<tr>
<td>Compliance checking systems</td>
<td>State/federal reporting</td>
<td>Decision support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charge description master</td>
<td>Fraud management</td>
<td>Clinical systems - Problem list - Clinical documentation</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Data &amp; reporting sets (MDS, PAI, OASIS, HEDIS, ORYX)</td>
<td></td>
<td>Pharmacy systems</td>
<td></td>
</tr>
</tbody>
</table>
Step 8: Prepare Transition Road Map

- Review and revise implementation strategy based on results of the impact analysis and data collection requirements
- Develop material for MD communication plan
- Assess change management processes – ensure integration with other initiative messaging
- Provide physician training based upon assessment – fold into current meetings/forums
- Implement or tweak clinical documentation improvement plan
- Align outside resources for backup support for busy clinic MDs
  - Anticipate lower productivity depending on the magnitude of changes
  - Level set expectations/dependencies impacting the MD workstream
- Test systems and processes
- Assess budget against actual costs
  - Allocate 20% of total expenses

Step 8: Prepare Transition Road Map
Go-Live & Post Implementation

- Align resources with CDI and HIM coding teams to ensure physician review and analysis of continued gaps in documentation
- Integrate findings into current peer feedback mechanisms, provider profiles
- Conduct additional training sessions as needed
- Communicate successes/showcase results
**Step 8: Prepare Transition Road Map: Sample Data Integrity Timeline**

<table>
<thead>
<tr>
<th>Action</th>
<th>Due date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1: Organize the implementation effort – choose MD champions</td>
<td>01/31/14</td>
</tr>
<tr>
<td>Step 2: Conduct the clinical, operational and financial impact analysis</td>
<td>02/28/14</td>
</tr>
<tr>
<td>Step 3: Evaluate the MD impact analysis – documentation, capture, work flow analysis</td>
<td>07/31/14</td>
</tr>
<tr>
<td>Step 4: Organize cross-functional/initiative efforts</td>
<td>08/31/14</td>
</tr>
<tr>
<td>Step 5: Develop budget impact – MDs</td>
<td>11/30/14</td>
</tr>
<tr>
<td>Step 6: Internal system design and development</td>
<td>11/30/14–2/28/15</td>
</tr>
<tr>
<td> • Workflow redesign</td>
<td></td>
</tr>
<tr>
<td> • Policy development and deployment</td>
<td></td>
</tr>
<tr>
<td> • Outcomes measurement</td>
<td></td>
</tr>
<tr>
<td>Step 7: Development and deployment of the MD training plan</td>
<td>03/01/14–8/31/14</td>
</tr>
<tr>
<td>Step 8: Vendor strategies assessment and implementation – clinical documentation</td>
<td>09/30/14–10/31/14</td>
</tr>
<tr>
<td>Step 9: Implementation planning</td>
<td>11/30/14–12/31/14</td>
</tr>
<tr>
<td>Step 10: Implementation</td>
<td>01/3/15</td>
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</tbody>
</table>
Step 9: Implementation:
Physician Champion Selection Criteria

• Significant amount of clinical activity
• Respected by peers and colleagues both medical and administrative
• Effective communication skills amongst all specialties
• Medical vs. surgical background
  – Splitting roles with both a medical physician and surgeon bridges the divide
  – Procedural based
  – Ambulatory vs. hospital based

Step 9: Implementation:
Deploy Effective Physician Documentation Strategy Execution

• Prepare implementation checklist to ensure that:
  – Note bloat, note cloning, etc. are a thing of the past
  – Templated physician progress notes for specific disease processes are being utilized and are well accepted by the physicians
  – Comparative data is regularly presented at department and section meetings of the medical staff
  – Metrics are established to ensure optimal outcomes are achieved and sustained
Monitoring the Program

• Physician education
  – One-on-one
  – Group
  – Specialty focused
• Promote the program
  – Ask for inclusion in medical staff executive agenda as standing item
  – Develop documentation tips by department
• Use newsletter or intranet source
• Physician documentation report card
  – Acknowledgement for best documenters

Step 10: Establish Reporting Metrics

Gauge the success of your clinical documentation improvement effort by developing a reporting dashboard and defining the key performance indicators (KPIs) from which to evaluate your successful achievement of your goals
Continuous Assessment and Outcomes Monitoring

- Perform assessments before implementation where possible – *never too late (reassessment)*
- Stay engaged and aware of enhancements post-implementation to evaluate compliance impact
- Target ongoing monitoring (metrics) and audit identified risk areas

**REMEMBER:** *The EHR is a tool to support the organization’s work, and is only as compliant as the configuration and workflows implemented*

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Developing and Defining the Data Quality Metrics

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Collection</th>
<th>Measurement interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical data capture</td>
<td>97% of entries populated</td>
<td>Random review of 20 records</td>
<td>Monthly</td>
</tr>
<tr>
<td>Clinical content</td>
<td>Fields populated accurately without inconsistencies or errors in dates, times, references to patient, past medical history, or history of present illness</td>
<td>Random review of 20 records</td>
<td>Monthly</td>
</tr>
<tr>
<td>Clinical data integrity</td>
<td>Fields populated with original content, not previously documented</td>
<td>Random review of 20 records</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
Unaddressed Documentation Issues Will Remain After the Transition to ICD-10

If the initial suspicion was pneumonia but the clinical course and findings did not truly support that diagnosis ...

• Documentation is a legal representation of the care and services provided
• Documentation is the cornerstone to disease and treatment information
• Aids in clinical decision-making
• Documentation can and will demonstrate the quality of care
• Documentation is needed for payment
• Documentation is a compliance necessity

Closing Remarks/Questions

• 10 steps to engage MDs
• Enabling technologies
• Educational strategies
• Policies
• Program metrics
• Monitoring and oversight
• Best practices to manage optimal record content
Thank you. Questions?

In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section at the front of the workbook.