

## **ANNUAL REPORT (June – May, 2010-2011)**

### **CLINICAL DOCUMENTATION COMMITTEE**

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The following is a summary of the major activities of the Clinical Documentation Committee during June through May, 2010-2011. This report is prepared to communicate the activities of the Committee to the Medical Staff and to meet The Joint Commission requirements.

#### **MEMBERSHIP:**

The Committee initiated and completed the year with the following members: Donald Spencer, MD, Chairman (Family Medicine); Robert Berger, MD (Medicine); Rowell Daniels (Pharmacy); Lynn Fordham, M.D. (Radiology); Catherine Hammett-Stabler, PhD (Pathology); Michael Hill, MD (Psychiatry); Larry Mandelkehr (CQI); Douglas Mann, MD (Neurology); Tracy Parham (ISD); Joni Perry, RHIA (MIM); Mary Angel, RHIT (MIM); Austin Rose, MD (ENT); Robert Tomsick, MD (Dermatology); Sherry Brown, RN (Nursing Practice, Education & Research); Lukas Castillo, RHIA (MIM); John Hart (Audit & Compliance); Emil Usinger (MIM); Beverly Wagner, RN (Clinical Care Management); Gina Bertolini (Legal); Chris Ellington (Administration); Pat Yee (Nursing), Laura Harmon (Accreditation); Tim Sadiq, MD (Surgery), Mary Ann Oertel (Pharmacy); Tom Hartley (UNC P&A); Davia Silberman (Radiology).

During the year, the following members were added to the Committee: James Larson, MD (Emergency Medicine); Elizabeth Forshay (Pharmacy)

The following departments currently do not have representatives on the Committee: Anesthesiology, Dental, OB/GYN, Ophthalmology, Orthopedics and House Staff Representative for Medicine and Surgery.

#### **ACTION TAKEN:**

- 1. CDC Topical Focus Plan:** The Committee updated the Topical Focus Plan which is used as a guide for future meeting topics and issues to be addressed. Some of the new topics added to the 2010/2011 plan are: Clinic Note Report monitoring (improved delayed documentation report), Education regarding “Meaningful Use” under ARRA, Meaningful Use: Physician report card, NCQA and BCBS Quality Partnership parameters, Education on Patient Portal including patient result reporting,

Education on ICD-10-CM/PCS, Copying and Pasting Policy and Procedure, Education for MD's about documentation issues (use of tools such as webinars, pod-casts, online self learning modules, etc.)

2. **Ongoing Record Review Plan FY2011 & Schedule:** The Committee approved this year's "Ongoing Records Review Plan. The schedule for Ongoing Record reviews for the fiscal year was developed and approved.
3. **Documentation Improvement: Updated Improvements to My DX list/POA/HAC and Source of Origin.** The New version of WebCIS that is aimed at improving the capture of complication and comorbidities of our patients that would therefore improving our rankings in US News and World report, UHC, and case mix. The Committee reviewed and provided input to the system build for capturing and improving documentation and has continued to monitor the impact of the work necessary by the housestaff to use the system.
4. **Ongoing Medical Record Reviews:** A number of ongoing medical record reviews were performed monthly and results were reported to the Committee for appropriate action. Reviews included: Outpatient H&P; Updated EMTALA Review; H&P Completion for Moderate Sedation; Baseline Review; Patient Discharge Information Review; PACU Documentation Review; Provisional and Final Autopsy Report; EMTALA Patient Transfer Form Review and Operative Report Review. The findings of the reviews and requests for plans of action to address areas out of compliance were communicated to the appropriate departments and individuals including recommendations for Executive Committee action if applicable. Focus was placed on the Joint Commission standards in preparation for the triennial survey coming up this year.
5. **Planning for ICD-10 Implementation:** The Committee was given an overview on ICD-10 and what the organization is doing to prepare. Since ICD-9 will be going to ICD-10 it is really going to have an impact on physician documentation which will have an effect on the Committee. ICD-10 is the next version of the code set representing Diagnoses and Inpatient Procedures. The implementation date for ICD-10 is October 1, 2013. ICD-10 will affect a multitude of sectors and staff and will have a big impact on coders. It will also be tied to reimbursement as well. There is a task force that has been formed to help with ICD-10 preparation and they are creating awareness throughout the organization. The Committee will be a resource to help with documentation needs and assessment in preparation for ICD 10.
6. **Forms Review:** The Committee, utilizing a pre-Committee review process, approved 29 new paper forms and 19 revised paper forms, and 4 Online Charting Projects.

- 7. E-chart Affecting Dosing Weight and CPOE:** Awareness is being raised for the various types of weight that are documented in the systems. A sub-group met to put together a list of definitions for the different weights that are used in the system. The Committee provided input to those definitions.
- 8. Copying and Pasting Policy/Procedure:** This was brought to the Committee to further raise awareness on this issue and to form a subcommittee to work on a policy and procedure. An article on “Audit of EHR Cloning Yields Documentation Problems That Put Compliance at Risk” caught the eye of many and prompted some research on the topic. Policies from various institutions were obtained and found that no one prohibits it but they do discourage it and provide guidelines on how to use the functionality. There was a Sub-Committee formed who has drafted a policy and continues to work on a final draft before submitting to the MSEC.
- 9. Meaningful Use:** A presentation was made to the Committee regarding meaningful use and the steps to certification. The members asked questions and provided lots of feedback. The Committee will be kept abreast throughout the process.
- 10. Delinquency Time Frames:** The Committee has responsibility for chart completion timeframes and therefore took the opportunity to review the policy for defining a delinquent medical record. While our delinquency rate continues to drop due to electronic initiatives, the demand from users of the documentation increases their need for quicker completion. Therefore, the committee is considering proposing a revision to the current delinquency time frame to one that is more stringent. Data is currently being collected in a parallel fashion to determine the impact on our percentage so that it doesn’t negatively impact Joint Commission standards. This will be presented to the Committee shortly after our next Joint Commission survey.
- 11. Medical Staff Privacy Violations:** The Committee continues to be responsible for reviewing corrective action letters provided to the Medical Staff as a result of privacy violations. The Committee reviewed 3 violations that were recommended to be forwarded to the credentials file.
- 12. WebCIS Monthly Report:** Dr. Berger/Tracy Parham continue to provide reports each month on the status of the development of the electronic record and request input provided by the Committee members and address issues related to regulatory requirements, etc. as necessary.
- 13. Departmental Report and Key Indicators:** The Committee continued to review the key indicators presented by the MIM Department to assure compliance with The Joint Commission standards and hospital policy for turnaround times including

loose material received, scanning metrics, undictated operative reports, total delinquent records, and transcription turnaround times. New indicators were added such as Outstanding Coding Queries and query response turnaround, Severity of Illness, Risk of Mortality and Case Mix Index scores to demonstrate the effectiveness of our Documentation Improvement Program. Release of information to patients' turnaround time was also added to support our reporting on Meaningful Use.

- 14. General Consent for Procedure Discussion:** The Committee discussed the issue with the General Consent for Procedure form that allows the Physician/Surgeon to input the name of the procedure. The arising problem is there are more and more requests to develop forms for specific procedures which will lead to a multitude of forms. The Committee and Legal have both agreed that the focus should be to direct requestors to stick with the general procedure consent form and provide education to the physicians who are explaining the risks and benefits to the patient and individual requests to have specific consents will be evaluated on a case by case basis.
- 15. Demo for OB Documentation System:** A demo was presented to the Committee on Prenatal and Postnatal records. These records will be done in WebCIS but the intrapartum (in labor) will be done in e-Chart since all the other documentation is there. Once the first note is done the following notes will be very quick and efficient. The Committee will continue to stay abreast throughout the implementation.
- 16. Documentation & Imaging Document Types in WebCIS:** The Committee reviewed the approved list of document types based on a request to add document types that are very specific to a department. The pros and cons to increasing that list of document types were discussed. The Committee considered the possibility of adding a third column where the actual MIM Form name would be imbedded and displayed to improve the search capability for a specific document, but this would have to be done in Sovera 10. It was also suggested to add a specific doc type in the bar code and the information would be placed in the header information that is read by WebCIS. The Committee agreed to further investigate the addition of the third column and to investigate the time frame for implementation of Sovera Version 10.
- 17. Proposal for Delinquent OP Report Revisions:** The Committee discussed the impact and process if the current way of reporting was changed. It was requested that a significant change be made by holding the attending physician accountable in every case and not report the dictating physician. Currently a monthly report is generated out of the database that is used to create the daily delinquent OP Report which identifies the top ten offending physicians (dictator only) and this is based on the number of charts and days. Two in a row results in a warning letter and three in a row results in a letter to the credentialing file. The Committee is recommending to MSEC that the daily reporting of delinquent OP notes will remain unchanged but the

Committee Credentialing process will be changed to only track the Attending listed and only report the attending to Peer Review.

**18. Review of Administrative Probation Policy:** The Committee reviewed the Administrative Probation policy that was revised about 3 years ago. A number of questions had arisen since physicians had been placed on Pending Administrative Probation for a delinquency in a coding query. The Committee agreed with the current policy as it is written, but suggested that the policy itself be formatted for inclusion in the Health Care System Policy manual. The Rules and Regulations adequately refer to the process that is monitored by the Committee.

### **ITEMS OUTSTANDING:**

- 1) **Electronic Medical Record/WebCIS Reports:** The Committee will continue to provide feedback to Dr. Berger and Ms. Parham to enhance the electronic medical record. In addition, the CDC will continue to assess the scope of support and process by which the Committee will provide when requests for functional changes to the electronic record are submitted. The Committee will continue to evolve surrounding the scope of responsibility which may include a more focused review of clinical content that also involves consideration for workflows and the processes.
- 2) **Ongoing Medical Record Reviews:** The ongoing medical record reviews will continue to be performed on at least a quarterly basis to identify areas of documentation improvement needs and to meet The Joint Commission requirements. Focused areas that continue to need periodic reviews include restraints and seclusion documentation which are standards.
- 3) **Documentation Improvement initiatives:** With the demands being placed upon electronic medical records and more thorough documentation and the upcoming RAC's, the Committee will continue to provide input and be a resource for ideas to improve and enhance the Documentation Improvement Program. In addition, the Committee will support efforts to improve SOI & ROM through improved documentation and coding.
- 4) **Electronic WebCIS Templates and Forms:** The Committee continues to work through the processes for reviewing and approving electronic medical record templates by reducing paper form requests and will work through the forms subcommittee represented by ISD.

- 5) **Copying and Pasting Policy/Procedure:** The subcommittee continues to work on this policy and will meet to finalize and then present to the full Committee. The Committee will forward this recommendation to the MSEC for adoption.
  
- 6) **Committee Membership:** The Committee has requested assistance from the Medical Staff Executive Committee to recommend physicians to represent those departments that currently are not represented on the CDC Committee. The representatives needed are listed above. With the evolving use of the electronic medical record and its impact on documentation as well as the external regulatory requirements that demand higher standards for medical record documentation, the need to have a representative from each clinical department is imperative.

Donald Spencer, M.D., MBA, Chairman  
Clinical Documentation Committee  
May 19, 2010