

ANNUAL REPORT (June – May, 2009-2010) CLINICAL DOCUMENTATION COMMITTEE

The following is a summary of the major activities of the Clinical Documentation Committee during June through May, 2009-2010. 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); Alden Parsons, MD (Housestaff-Surgery); Joni Perry, RHIA (MIM); Melissa Rajappan, RHIA (MIM); Austin Rose, MD (ENT) and 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).

During the year, the following members were added to the Committee: Gina Bertolini, Legal; Chris Ellington, Administration; Pat Yee, Nursing; Laura Harmon, Accreditation, Tim Sadiq, MD, Surgery, Mary Ann Oertel, Pharmacy and Tom Hartley, UNC P&A.

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

ACTION TAKEN:

- 1) **CDC Topical Focus Plan:** The Committee concluded that the topics on the current Topical Focus Plan served its purpose and it is time to start over with new topics that the committee members might find important to address. The new Topical Focus Plan was updated and used as a guide for future meeting topics. Some of the new topics added to the plan are: Order set review and policies in CPOE, Definition of admission date and Education on EMAR.
- 2) **Ongoing Record Review Plan FY2010 & Schedule:** The Committee approved this year's "Ongoing Records Review Plan", previously named the "Documentation Improvement Plan". The schedule for Ongoing Record reviews for the fiscal year was developed and approved.
- 3) **Removing PHI from the Hospital Premises:** The Committee discussed that the old policy for medical records not leaving the premises unless under court order has been removed because electronic medical records are now in use therefore revisions to several policies were made to reflect electronic medical records.

- 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 ED Documentation Review, Patient Discharge Information, Baseline Review, Focus Review on Operative Report, PACU Documentation, Restraint & Seclusions – Behavioral/Non Behavioral, Brief OP Note, Inpatient H&P, Outpatient H&P, Review of Provisional Anatomic Diagnosis and Autopsy Final Reports, 2009 Organ and Tissue Donation Scorecard, Prohibited Abbreviations and Discharge Summary. 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.
- 5) **Daily Physician Progress Notes in the Medical Record:** The Committee discussed that no where in the rules and regulations requires a physician to enter a progress note on a daily basis. The Committee voted that the Medical Staff rules and regulations be revised to include that there be a required daily progress note. A recommendation was referred to the Medical Executive Staff Committee that the Rules and Regulations be updated to include a requirement that a provider must document a daily progress note in the patient's inpatient medical record. This was approved by the MSEC on 1/11/2010.
- 6) **Forms Review:** The Committee, utilizing a pre-Committee review process, approved 62 new paper forms and 13 revised paper forms, 2 Pilots and 5 Online Charting Projects.
- 7) **Joint Commission Mock Survey Action Plan:** It was discussed by the Committee that a mock survey was done in preparation for Joint Commission and as of January we are within the window that we could have an unannounced survey. It was brought forth that a big topic this year was the date and time of signed entries. Most of our forms do not have a space for the time so it was decided to go through our most popular used forms and have the printing department add a space for the time. The providers will be educated to document their signature with the time and date. The Committee will push towards computerized documents and forms.
- 8) **Manual entry of written Progress Notes:** The Committee discussed and notes that there are still some services that write Inpatient Progress Notes and two are OB and Orthopedics. The Committee unanimously voted to require that all Physicians implement documenting their inpatient Progress Notes electronically by the end of the calendar year. The Committee's vote was sent as a formal recommendation to the Medical Executive Staff Committee. The MSEC approved this recommendation unanimously on 5/10/2010.
- 9) **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 had one physician that received a letter for violations for approval to be reported to the Credentials Committee for consideration in the reappointment process.

- 10) UHC Data on ROM &SOI – Documentation Impact:** It was discussed by the Committee how data such as Diagnosis, Procedures and Demographic Information is sent to a number of different organizations including Medicare for reimbursement purposes and to UHC in which data is shared, benchmarked and we work together to find ways to provide better care. This is being used as a way to gauge the quality of care that we provide to our patients. The Committee discussed a comparison of information on UNC DRG information with other hospitals, and the results indicated longer length of stays and greater mortality rates than what was expected. It was discussed as to how proper documentation could help address this discrepancy and how MIM's Documentation Improvement Program is already working. A recommendation was made to get the Committee's support to provide additional resources to address concerns. The Committee will incorporate reviewing Documentation issues and indicators at its monthly meeting.
- 11) CMS Requirement for Signature Legibility/Attestation:** The Committee discussed some changes that have been issued in the Signature guidelines for medical review purposes. These changes went into effect March 1st, 2010. Medicare now requires entry for services provided to be authenticated by the author in a legible manner and will deny payment if not. If the Physicians signature is illegible and there is no typed printed name or letterhead clarifying the physician's signature then we have to submit an attestation statement signed by the physician in order to get paid.
- 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. The current department report is now under revision to delete certain items and add others as a result of the changes to the Committees focus.

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) **MIM Department Report:** A new format to the department report is being developed to include DIP indicators and meaningful use items as well as other important items to monitor.
- 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

**CLINICAL DOCUMENTATION COMMITTEE
TOPICAL FOCUS PLAN 2009/2010**

TOPIC	TASK FORCE OR ENTIRE COMMITTEE	RESOURCE PEOPLE	MONTH of Completion	OUTCOME
Advanced Directive Problem Identification (ie advanced care planning, DNR, etc. – define and how it needs to flow)	Committee	Tracy Parham		
HIPAA Update/ Post ARRA	Committee	John Hart		
Order set review and policies in CPOE	Committee or Forms Subcommittee	Tracy Parham and Emil Usinger		
Definition of “admission date”	Committee	Tracy Parham, Beverly Wagner, Joni Perry		
Lab order forms across clinics	Committee or Forms Subcommittee	Franklin Farmer and Emil Usinger		
Clinic report monitoring (improve delayed documentation report so it is cumulative)	Committee	Raj Gopalan		
Education regarding “Meaningful Use” under ARRA	Committee	Raj Gopalan		
Meaningful Use: Physician report card	Committee or possibly a Task Force	JP Kichak		
NCQA and BCBS Quality Partnership	Committee	Rob Malone		

TOPIC	TASK FORCE OR ENTIRE COMMITTEE	RESOURCE PEOPLE	MONTH of Completion	OUTCOME
parameters				
Implications of Siemens Acquisition including WebCIS template building and other requests	Committee	JP Kichak		
Education on Patient Portal including patient result reporting	Committee	Raj Gopalan		
Documentation completion timeframe metrics (ie, reducing H&P timeframes, etc.)	Committee and MSEC	Beverly Wagner		
Education on EMAR	Committee	Tracy Parham		
Faculty checkout for completion of documents	Committee	Joni Perry		
Education for MD's about documentation issues (use of tools such as webinars, pod-casts, online self learning modules, etc.)	Committee and MSEC	Joni Perry and Beverly Wagner		
Education on ICD-10	Committee	Joni Perry		
Documentation of daily hospital progress note (recommend ms rules and regs for daily progress notes)	Committee and MSEC	Gina Bertolini and Legal Dept.	October 2009	MSEC approved on 1/11/10 to require progress note for each patient on each calendar day
Streamlining documentation process in EMR	Committee	Donald Spencer, MD		
Removing PHI from hospital premises policy	Committee	Joni Perry	September 2009	Committee suggested reviewing all related policies to gear them

TOPIC	TASK FORCE OR ENTIRE COMMITTEE	RESOURCE PEOPLE	MONTH of Completion	OUTCOME
				towards electronic MR. Have begun that process with Legal.