improving clinical documentation in an EMR world

One health system used a three-step process to integrate a clinical documentation improvement program with its new electronic medical record system, with significant results.

Implementing an electronic medical record (EMR) was no easy task for the University of Washington’s UW Medicine health system, based in Seattle. After the implementation, UW Medicine decided to maximize its potential by integrating a clinical documentation program into the work flow, which presented additional challenges but yielded significant improvement in quality and patient safety.

UW Medicine’s push to implement an EMR system, including the capture of all inpatient notes, put it within a small circle of hospitals adopting EMRs and planning to eventually venture into a full, comprehensive EMR system. Hospitals are slow to adopt paperless records systems. One study found that only 1.5 percent of nonfederal, U.S. hospitals use a comprehensive EMR system, and only about 12 percent have fully implemented electronic physician notes in all units (Jha, A.K., et al., “Use of Electronic Health Records in U.S. Hospitals,” New England Journal of Medicine, Mar. 25, 2009). From the very start of UW Medicine’s EMR implementation, the system’s leaders wanted to ensure that this substantial investment would yield a multitude of benefits.

UW Medicine was particularly concerned about its ability to meet Medicare’s focus on pay for performance and value-based purchasing. First, the health system required a process that first and foremost allowed its physicians to clearly document the acuity of their patients and get credit for the value they deliver. Second, the health system wanted a comprehensive program that would allow its clinical teams to identify and appropriately manage all clinical conditions from arrival in the hospital to discharge, helping further improve outcomes, reduce unnecessary readmissions, and improve the overall quality of care.
UW Medicine's leaders decided to integrate a clinical documentation improvement (CDI) program with its new EMR system. To strengthen the program, they formed a new group of specialists called registered nurse documentation specialists (RNDSs), who are tasked to request clinically significant documentation clarification that could affect patient safety and quality of care.

Implementing an EMR and a new CDI program required a three-step, proactive process, heavy on education and planning:
> Make sure physicians are engaged and understand the process.
> Create a workflow, bolstered through IT, that is easy for physicians to use.
> Recruit and train RNDSs, who are clinically sophisticated and able to request clinically significant clarifications.

**Getting Physicians on Board**

Although EMR integration with CDI is partly an IT endeavor, success in improving clinical documentation hinges on physician buy-in. The success of UW Medicine's program depended upon cooperative relationships among the physicians, the RNDSs, and a physician champion.

During clinical staff meetings, the chief nurse officer (CNO), chief medical officer (CMO), and a physician champion cultivate buy-in by explaining the goals and importance of the program to physicians. In addition, an external consultant was hired to help the physicians—who were already overwhelmed by the business and regulatory side of medicine—understand why supporting efforts to be more precise in clinical documentation was in their best interest. After becoming informed about how clinical documentation affects physicians' pay for performance, provider profiling, medical/legal risk, and severity of illness reporting, the physicians understood the benefit of learning the key elements of the new severity-adjusted documentation and coding system.

Physicians need to understand the fundamental rules of documentation and coding, even though they do not know all the details involved in those rules. Physicians need to rely on their support infrastructure—a team of RNDSs who can present...
information from the clinical record in a manner allowing easy compliance with Medicare rules and regulations. Once physicians learn how to use their support team, they can get to the most accurate code efficiently and quickly.

The physician champion approached the task of gaining buy-in from UW Medicine’s physicians by candidly admitting that the new documentation procedure was tedious, thereby gaining their trust. In addition, the champion motivated physicians by appealing to their pride. Physicians want to be respected by other physicians and will compare their success against others.

**Make It Simple for Physicians**

The transition to a new documentation method had to be simple for physicians. Integrating a CDI program with an EMR system meant that clinically trained and integrated RNDSs could review documentation concurrently and ensure that the physicians were being as precise as possible when capturing severity of illness and the acuity of a patient’s condition. It was important to make an RNDS’s physician query form as simple and straightforward as possible.

To build an intuitive and successful diagnosis clarification process, UW Medicine leaders considered the following questions:

> How will the physician receive the diagnosis clarification request (e.g., e-mail inbox, pagers, a messaging program, or all of the above)?
> How will clarifications be prioritized?
> What method can physicians use to respond (e.g., an accept/decline option, an e-signature, or another method)?
> How can the process be simplified for physicians (e.g., keep the clarification process in one window versus opening different views)?
> What can be done to ensure that coders have easy access to the physician clarification response?

Once UW Medicine physicians became comfortable using e-mail and logging into the EMR system, the system’s leaders knew they could build on that familiarity to simplify the query process.

Physicians who see the future and understand the financial implications of severity adjustment for outcomes will take the time to change their terminology to enhance clinical accuracy.

When the RNDSs review the patient record and notice an opportunity to clarify a diagnosis, they have two options: Send the physician a simple communication via e-mail, or create a message to be posted within the EMR, as shown in the exhibit on page 73.

For example, if an RNDS notices that a physician has used the term acute renal insufficiency (ARI) when the clinical situation supports the diagnosis of acute renal failure, the RNDS can send the physician a message with the subject line “Diagnosis Clarification.” Clarification requests are based on the physician’s clinical opinion using the “three-legged stool” methodology: risk factors, clinical indicators, and treatment. A clarification request might read: “Is the patient also being managed for acute renal failure based on risk factors of ‘volume depletion’...? If so, please check your response below.” If the physician agrees by checking a box, a follow-up document is sent requiring the physician’s signature using an automatically prepared button at the bottom that says “sign.” Then the physician has a second chance to edit, accept, or refuse the clarification. By clicking the “accept” box, the physician has formally documented the diagnosis. When physicians disagree with a suggested change, they simply indicate “disagree” and nothing further happens.
Once a physician digitally signs the diagnosis clarification, the diagnosis is added to the automated problem list by the RNDS. The problem list is automatically imported into inpatient notes, ensuring that the next progress note includes the problem list and the new ARF diagnosis with no extra effort required of the physician. From this point forward, all subsequent documents will contain the new diagnosis, thus creating a dynamic problem list.

**Train RNDSs to Support Physician Documentation Clarification**

UW Medicine created the position of RNDS to support the CDI program, currently employing seven. The RNDSs are charged with using their clinical and analytical skills to capture clinical documentation from admission through discharge, with a focus on precisely documenting conditions that affect patient safety and quality of care at the time of treatment and that could present future problems. Although RNDSs should have a solid foundation in such knowledge and skills when they are hired for this position, they also will require substantial training to ensure that they can perform their duties at the highest level.

Because the role requires review and analysis of complex clinical finding, the RNDS needs strong foundational knowledge in specialty nursing, preferably critical care. Critical thinking skills are essential. Additional training involves learning to use the software application—in our case, the majority of application training is done by the vendor. Our RNDS staff report to a manager who is a part of our Center for Clinical Excellence (or quality improvement department). Situating this work under the quality umbrella has been a key factor in its success. UW Medicine could not have achieved the results it has seen if the RNDSs had not been a part of its quality structure and processes.

**Quality Leads, but Financial Rewards Follow**

In general, the CDI program has helped UW Medicine improve the quality of its care. Leaders are seeing fewer misclassifications and are better able to determine which patients require earlier intervention and to bring them into pathways more quickly.

UW Medicine reaped quantitative rewards in the two important areas. Case mix index increased from 1.92 in FY08 to 2.07 in FY09 because documentation now more accurately captures the severity of

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**EXAMPLE OF MESSAGE FROM RNDS TO PHYSICIAN REGARDING CLINICAL DOCUMENTATION CLARIFICATION**

Medicare requires the use of specific language to capture the severity and acuity of patients. This clarification is being sent from ________, RN documentation specialist.

Please render your clinical opinion if patient is also being managed for acute renal failure based on the risk factors of "volume depletion"; clinical s/s "creatinine elevated to 1.8 from baseline of ~1.2"; chart documentation "ART" and treatment "follow with volume repletion."

Please check your response below. If you agree, I will update the problem list and prepare the clarification note for your electronic signature. It will appear for signature in your ORCA message in-box.

(x) Agree         ( ) Disagree

Thanks!
FEATURE STORY

UW Medicine’s case mix index increased from 1.92 in FY08 to 2.07 in FY09 because documentation now more accurately captures the severity of illness.

illness. Also, expected and observed mortality ratios demonstrate less mortality than expected. UW Medicine’s O/E ratio (the mortality index) is now competitive with top academic medical centers.

The overall result of the CDI program has been a significant improvement in quality and patient safety by incorporating documentation into the clinical process. This result improves not only severity-adjusted outcomes but also raw (observed) outcomes by improving communication among members of the clinical team to ensure the highest quality of care for the patients, with the RNDS as the important linchpin.

Keeping the Program Strong

The CNO, CMO, CFO, RNDS manager, coding manager, quality manager, and health information manager meet monthly to review reports that show the rate of query requests, physician response, physician agreement, and overall case mix index. Success requires an interdisciplinary effort. Even with a physician champion leading the charge, some physicians will still be reluctant to support the effort. Many physicians wonder, “Why must I change my terminology?”

UW Medicine leaders understand that if physicians use the proper terminology the first time, there is less work for all involved. Granted, that is easier said than done. For example, physicians have used the term congestive heart failure for decades to describe a patient’s condition, whereas the term can be applied to many different conditions, including acute congestive heart failure, chronic congestive heart failure, and right- and left-sided heart failure. In many such instances, physicians are now being asked to use greater clinical specificity, not only for billing purposes, but also to capture clinical severity. Clinical severity is critically important to physicians as Medicare and other insurers move rapidly to severity-adjusted physician profiles and pay for performance.

Physicians who see the future and understand the financial implications of severity adjustment for outcomes will change their terminology to enhance clinical accuracy. Those physicians who do not participate will see their colleagues’ severity-adjusted mortality rates fall while their own profiling will not measure up to their peers. This is the ultimate motivator.

UW Medicine now has a concurrent EMR—one that allows physicians and RNDSs to clarify and ensure that diagnoses are accurate and predictive of patients’ problems and risk for readmission. The payoffs have been worth the investment of time and money.

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