Quality Assurance (QA)
for
Clinician-Created Documentation

The Need for Quality Assurance

- ***Patient safety can be compromised***
- ***Incomplete or inaccurate documentation***
- ***Lost revenue***

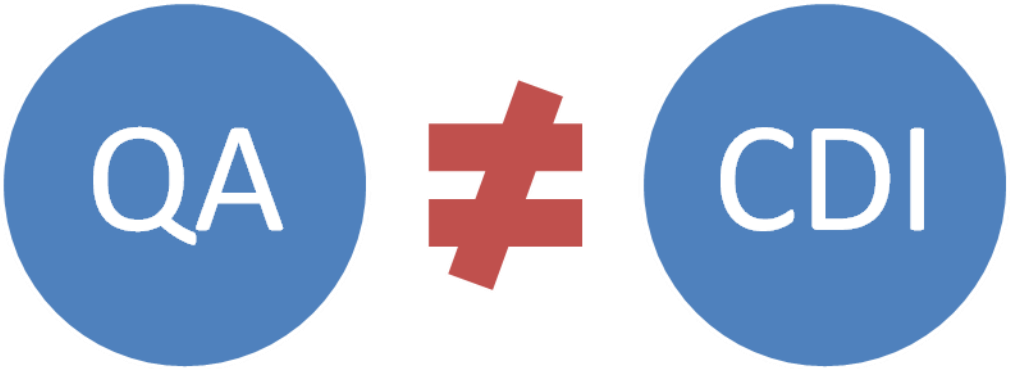
* *In considering these potential negative consequences, the upfront expense of a QA program outweighs the far-reaching and long-term impacts of forgoing a QA Program.*

The Need for Quality Assurance

A Quality Assurance (QA) program

is not

A Clinical Documentation Improvement (CDI) program



The Need for Quality Assurance

- A CDI program facilitates the accurate representation of a patient's clinical status that translates into coded data.[1]

- A QA program is the **COMPLETE REVIEW** of the narrative and demographic data to protect the patient, caregiver(s), and the organization's documentation integrity.

[1]http://www.ahima.org/topics/cdi

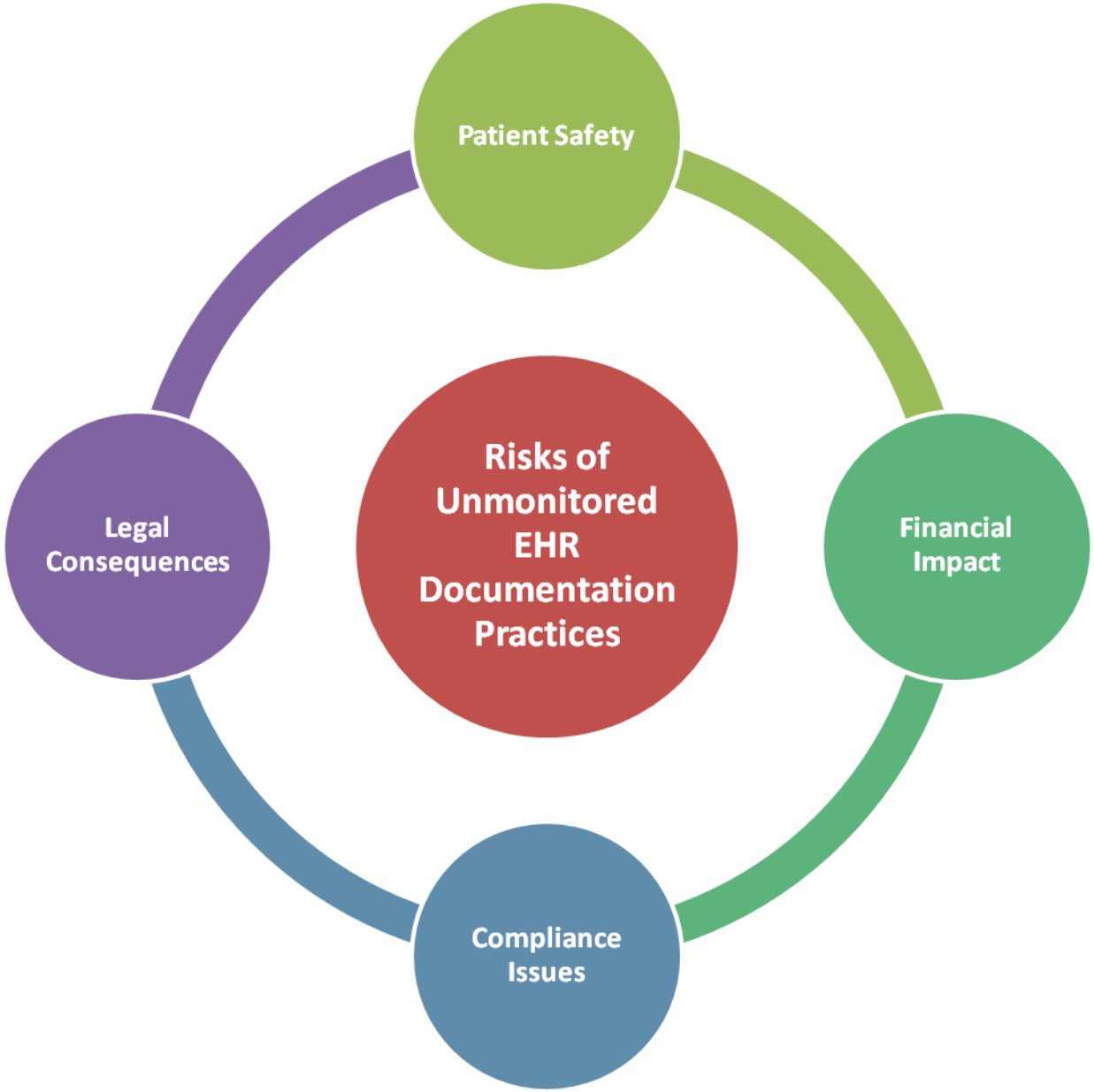
The Need for Quality Assurance

Organizations should incorporate

BOTH

programs to ensure documentation integrity and regulatory compliance throughout the healthcare continuum.

The Need for Quality Assurance



The Need for Quality Assurance

Common EHR Practices that Create Vulnerabilities

1. Copy and paste or “note bloat”

2. Lack of review, correction, and feedback

3. Unmanaged/inconsistent template creation and modification leading to automation errors

4. System(s) designed and built with limited healthcare documentation expertise

The Need for Quality Assurance

- **Additional vulnerabilities:**
  - Inappropriate abbreviations
  - Inappropriate templates
  - Wrong patient/wrong visit
  - Selecting incorrect check boxes
  - Speech “wrecks”

The Need for Quality Assurance

Best practices should be used to protect the integrity of the patient's health information.

HEART **PATIENT SAFETY**

Fraud is not the only concern.

Complete and accurate documentation reduces errors, improves management, and ensures appropriate funding.

The healthcare professionals behind quality assurance programs

WORKFORCE AND SKILL SETS

The Role of the Healthcare Documentation Specialist (HDS)

1. Produces documentation that reflects the patient's story in a correct, complete, and consistent manner

2. Ensures accurate documentation

2. Creates a business record that can be trusted and referenced

The Role of the Healthcare Documentation Specialist (HDS)

- **Reviews** healthcare documentation content and provides feedback to clinician
- **Develops** and maintains template design program
- **Trains** clinicians on template usage
- **Collaborates** with key stakeholders
- **Includes** the patient in documentation process whenever deemed possible
- **Strives** for continuous quality improvement

The Role of the Healthcare Documentation Specialist (HDS)

- Reviews and flags documentation
  - ✓ Validates patient and visit demographics
  - ✓ Flags critical errors for correction
  - ✓ Identifies minor errors
- Provides feedback to the originating clinician
- Content review assists with coding and reimbursement and template creation

AHDI-AHIMA Clinician-Created Documentation Resource Kit

- Error Categories
- Dashboards and Trending/Tracking Spreadsheets
  - Best practices, Examples, and Templates
- QA Review Form Template and Sample
- QA Program Checklist
- QA Program Sample Policies/Procedures
- Model Job Descriptions
- Documentation Review Forms and Samples
- Video Tutorial

Resources

- AHDI-AHIMA Clinician-Created Documentation Resource Kit
- A Guide to Better Physician Documentation
- AHDI/MTIA/AHIMA Healthcare Documentation Quality Assessment and Management Best Practices
- AHIMA Copy and Paste Position Statement
- Dimick, Chris. "Documentation Bad Habits: Shortcuts in Electronic Records Pose Risk." *Journal of AHIMA* 79, no.6 (June 2008): 40-43.
- The Joint Commission - Most Challenging Requirements in 2013