Clinical Documentation Requirements

Foundational Curriculum:
Cluster 2: Clinical Process
Module 2: Clinical Practice and Documentation
Unit 4: Clinical Documentation Requirements
FC-C2M2U4

Curriculum Developers: Angelique Blake, Rachelle Blake, Pauliina Hulkkonen, Sonja Huotari, Milla Jauhiainen, Johanna Tolonen, and Alpo Värri

1

Unit Objectives

- Identify the source of information entered in an electronic health record

- State the value of templates, prompts and macros as common data collection tools of clinical documentation

- Identify components of the Medical Health Record (paper, electronic, hybrid), including: - History - What care has been provided and what is outstanding - Systems Review - Physical examination - Assessment/impression - Current patient status and disposition

- Review the roles that remote and network-linked technologies play in clinical practice

- Describe organizational contingency plans when health IT systems are down

- Describe the work process when health IT systems are down

Sources of Information Entered in an EHR

- The electronic health record is meant to be a longitudinal coordinated record that promotes quality, evidence-based outcomes for patients
- Therefore, many times information may come from:
  - The **allied health team**, including physicians, nurses and other ancillary team members
  - Outside clinical and nonclinical providers and health organizations
  - Lab results, scanned records, and other interfaced data
  - Patient-entered data
- When possible, ensure you can identify the source of data, especially when you base your own documentation, impressions or recommendations off other data contained in the EHR

Templates, Prompts and Macros: Data Collection Tools of Clinical Documentation

- Clinical documentation can be facilitated through the effective use of EHR templates, prompts and macros:
  - **Templates**- preset structured formats for a section of a document, such as a history or physical examination. These can help support the capture of clinical content in a standardized and structured manner
  - **Prompts**- short suggestions or informational messages, sometimes interactive and/or offering further action options and often integrated with clinical decision support rules. These can lead to more meaningful patient data, improved outcomes, and more coordinated patient care
  - **Macros**- short words, symbols or phrases that expand automatically into complex set of actions, forms or templates. These help providers easily use customized complex content and work more efficiently

- Leveraging these data collection tools can improve clinical documentation, leading to a higher quality of care for the patient through a better understanding of complications, better design of clinically robust algorithms, and better tracking of the outcomes of care

Medical Health Record Components

- All health records should have some common elements for the patient regarding:
  - **subjective data-** unstructured, from the patient's perspective and
  - **objective data-** structured, from the provider's perspective
- These health records may come in the form of **electronic**, **paper** or **hybrid** – a combination of paper and electronic

Electronic

Paper-based

Hybrid

Medical Health Record Components (Cont'd)

- As we have reviewed in Module 1, the SOAP (subjective, objective, assessment and plan) and HPIP (history, physical, impression and plan) contain the following subjective and objective elements:
  - **History** (subjective): The patient describes what significant illnesses, injuries and treatments, including hospitalizations and surgeries, have taken place to date
  - **Review of systems** (subjective): The patient describes any problems, illnesses or injuries that have needed attention in all body systems
  - **Physical Examination** (objective): The provider evaluates the patient in all body systems for current problems
  - **Assessment/Impression** (objective): The provider assesses the patient, including rendering diagnoses and a current problem list.
  - **Plan** (objective): The provider devises a plan of action for best addressing any issues found on the assessment/impression, including possible treatments, medications, tests or referrals.
  - **Hospital Course**: in acute care, this is what care has been provided and what is outstanding. In non-acute care, this is documented in the history
  - **Disposition:** this includes interdisciplinary care planning (**ICP**) and current patient status and any transfer location such as a skilled nursing facility or rehabilitation unit.

Templates in Medical Health Records

- Many times providers use **templates** for some or all of their documentation. Some organizations allow templating, while others do not

- Following are some templated "normal" formats for the SOAP/HPIP report:
  - HISTORY: No changes since admission.
  - Review of Systems:
    - CONSTITUTIONAL: As per History of the Present Illness.
    - HEENT: Eyes: No eye pain. No complaints of diplopia or blurred vision. ENT: No earache, sore throat or runny nose.
    - CARDIOVASCULAR: No pressure, squeezing, strangling, tightness, heaviness or aching about the chest, neck, axilla or epigastrium.
    - RESPIRATORY: No cough, shortness of breath, paroxysmal nocturnal dyspnea or orthopnea.
    - GASTROINTESTINAL: No nausea, vomiting or diarrhea.
    - GENITOURINARY: No dysuria, frequency or urgency.
    - MUSCULOSKELETAL: As per history of present illness.
    - SKIN: No change in skin, hair or nails.
    - NEUROLOGIC: No paresthesias, fasciculations, seizures or weakness.
    - ENDOCRINE: No heat or cold intolerance, polyuria or polydipsia.
    - HEMATOLOGICAL: No easy bruising or bleeding.

Templates in Medical Health Records (Cont'd)

- Following are some templated "normal" formats for the SOAP/HPIP report (cont'd):
  - Physical Examination:
    - GENERAL: The patient is a well-developed, well-nourished fe/male in no apparent distress. S/he is alert and oriented x3.
    - VITAL SIGNS: Temperature XX, pulse XX, respirations XX, blood pressure XXX/XX, and O2 saturation XX% on room air.
    - HEENT: Head is normocephalic and atraumatic. Extraocular muscles are intact. Pupils are equal, round, and reactive to light and accommodation. Nares appeared normal. Mouth is well hydrated and without lesions. Mucous membranes are moist. Posterior pharynx is clear of any exudate or lesions.
    - NECK: Supple. No carotid bruits. No lymphadenopathy or thyromegaly.
    - LUNGS: Clear to auscultation and percussion.
    - HEART: Regular rate and rhythm without murmur.
    - ABDOMEN: Soft, nontender, and nondistended. Positive bowel sounds. No hepatosplenomegaly was noted.
    - EXTREMITIES: Without any cyanosis, clubbing, rash, lesions or edema.
    - NEUROLOGIC: Cranial nerves II through XII are grossly intact.
    - SKIN: Warm and dry. No exudates, erythema, ulcerations or indurations present.

Remote and Network-Linked Technologies in the Clinical Practice

- Remote and network technologies can aid in clinical documentation
- Many organizations allow providers to access the EHR remotely, to check results and view summaries. Some organizations allow remote documentation via network-linked technology.
- The following remote technologies and telehealth applications can also contribute to or enhance clinical documentation:
  - **Specialist referral services** typically involve a specialist assisting a general practitioner in rendering a diagnosis. This may involve a patient "seeing" a specialist over a live, remote consult or the transmission of diagnostic images and/or video along with patient data to a specialist for viewing later.
  - **Direct patient care services** includes sharing audio, video and medical data between a patient and a health professional for use in rendering a diagnosis, treatment plan, prescription or advice. This might involve patients located at a remote clinic, a physician's office or home.

FC-C2M2U4

Remote and Network-Linked Technologies in the Clinical Practice (cont'd)


- Remote patient monitoring uses devices to remotely collect and send data to a monitoring station for interpretation. Such "home telehealth" applications might include using telemetry devices to capture a specific vital sign, such as blood pressure, glucose, ECG or weight.

- Medical education and mentoring can enhance documentation, which can range from the provision of continuing medical education credits for health professionals and special medical education seminars for targeted groups, to interactive expert advice provided to another professional performing a medical procedure.

- Consumer medical and health information includes the use of the internet for consumers to obtain specialized health information and on-line discussion groups to provide peer-to-peer support.

FC-C2M2U4

EHR Systems Downtime Procedures, Policies, and Practices

- Occasional temporary unavailability of EHRs is inevitable, due to failures of software and hardware infrastructure, as well as power outages and natural and man-made disasters

- EHR safety and effectiveness can be improved by establishing proper downtime procedures, policies, and practices

- Effective contingency planning addresses the causes and consequences of EHR unavailability, and involves processes and preparations that can minimize the frequency and impact of such events, ensuring continuity of care
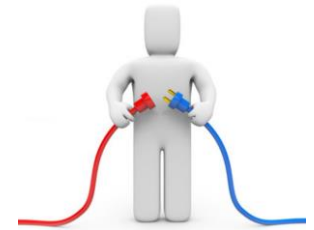
EHR Systems Downtime Procedures, Policies, and Practices (cont'd)

- You should be aware of your organization's downtime procedures
- An organization's EHR contingency plan ensures that the technical components align with and support the clinical processes and workflows impacted by their decisions
  - For example, clinical documentation may switch to a paper or hybrid process
  - The documents that were created during the downtime will need to be created in a manner that make them easily converted to a structured format and seamlessly integrated back into the EHR when it is back up
  - Therefore, the substitute workflows that must be designed and then employed during downtimes are particularly sensitive to clinician input and cooperation

Organizational Downtime Procedures

- Following is an example of an organizational downtime procedure:
  - Paper forms are available to replace key EHR functions during downtimes
  - The organization maintains enough paper forms to care for patients on an in-patient unit for at least 8 hours
    - Paper forms could include those required to enter orders and document the administration of medications, labs, and radiology on each unit.

Organizational Downtime Procedures (cont'd)

– There is a process in place to ensure that the information recorded on paper during the downtime gets entered and reconciled into the EHR following its reactivation (e.g., entering information as coded data, scanning of paper documents)

Unit Review Checklist

- ❑ Identified the source of information entered in an electronic health record (HL01)

- ❑ Stated the value of templates, prompts and macros as common data collection tools of clinical documentation (HL04)

- ❑ Identified components of the Medical Health Record (paper, electronic, hybrid), including: - History - What care has been provided and what is outstanding - Systems Review - Physical examination - Assessment/impression - Current patient status and disposition (HB08)

- ❑ Reviewed the roles that remote and network-linked technologies play in clinical practice (JB14)

- ❑ Described organizational contingency plans when health IT systems are down (JB13)

- ❑ Described the work processes when health IT systems are down (JB15)

Unit Review Exercise/Activity

- Locate three examples of telehealth technologies available in your area
  - If you cannot find examples in your area, use the internet to locate technologies available in other areas

Unit Exam

1. "A short suggestion or informational message, sometimes interactive and/or offering further action options, and often integrated with clinical decision support rules" defines a(n):

    a. Prompt

    b. Template

    c. Macro

    d. Algorithm

2. A combination of paper and electronic health record defines which of the following?

    a. A mixed case health record

    b. A hybrid health record

    c. A clinical decision support system

    d. A SOAP record

Unit Exam (cont'd)

3. Which of the following statements might be found on a "normal" review of systems?

   a. The patient is alert and oriented x3.

   b. The heart has a regular rate and rhythm.

   c. Cranial nerves II through XII are grossly intact.

   d. No eye pain. No complaints of blurred vision.

4. Which of the following is <u>not</u> an example of a telehealth application?

   a. Off-site referral specialist consultation through monitors with transmission of PACS images

   b. Remote patient monitoring devices

   c. PACS images from the Emergency Room viewed within the Radiology Information System

   d. Uploading video to help render a diagnosis

Unit Exam (cont'd)

5. Which of the following would typically be part of an organization's downtime procedure?

    a. Paper forms are available for a maximum of four hours during a downtime

    b. Paper forms used during the downtime can be scanned back into the EHR as unstructured data when downtime is concluded

    c. Downtime procedures apply to only scheduled downtimes, but not to those due to power failure, or natural or man-made disasters

    d. Paper forms are available to replace key EHR functions during downtimes, such as order entry, medications administration and documentation