Clinical Documentation Systems: Another Link Between Technology and Quality

Christina Beach Thielst, FACHE, chief operating officer, Santa Paula Hospital, Santa Paula, California, and John H. Gardner, chief executive officer, Logos Health Systems, Inc., Thousand Oaks, California

Everyone who works in the healthcare industry grapples with multiple pressures. Organizational leaders and managers face challenges related to delivering high-quality care, ensuring patient safety, reducing costs, and providing exceptional customer service. Professionals, caregivers, and workers alike strive to achieve balance between their professional pursuits and personal lives. In healthcare, technology has not only ushered in sophisticated tools, but it has also improved and complemented existing processes. This positive infusion of technology has caused many stakeholders in a healthcare organization to ask, "what can technology do for me?" As the past five installments of this column have declared, the simple answer to that question is, "a lot."

Following the track of the previous installments of this column, the focus here (the last in this series) is on emerging technological advances that promise to maximize the efficiency and effectiveness of one of the most important elements in the delivery of care—clinical documentation. We selected this particular topic to further drive the point that technology, when developed and applied appropriately, is a critical step in improving care quality.

THE TRADITIONAL METHOD FOR CAPTURING DATA

Data that come directly from the physician are arguably the most comprehensive and accurate information about a patient. Such data can be used for multiple purposes, including patient care, coding, reimbursement, and compliance. Physicians provide two types of patient information—subjective and objective. Subjective data include progress notes and consultation reports. Objective information, on the other hand, includes physical examination records as well as operative, procedure, laboratory, and imaging reports.

Traditionally, a physician dictates notes, reports, and other patient care information into a recorder. That dictation is then sent to a medical transcriptionist to be turned into a written document. However, such a method requires the physician to remember everything and not omit any important aspect of the patient's care and treatment. Under this system, the onus falls heavily on the physician. The reality, however, is that physicians, like other healthcare professionals and providers, are frequently multitasking, are invariably interrupted multiple times during the course

of a shift, and are often playing catch-up with paperwork. Often, the end result of this situation is that the physician fails to dictate all the required and helpful information or that the physician provides the information in a less-than-timely manner.

Many transcription companies have moved toward using "back-end voice recognition"—a method of turning speech into a draft that is then edited by the transcriptionist. This method is used not only to create greater production efficiencies but also to encourage direct physician engagement. Because this system does not require the physician to change his or her work flow, most physicians do not even realize that the voice-recognition system is in place. Despite its production advantages, however, the system is only as good as the physician's memory, because it still depends on the physician's diligence in dictating critical patient information. In turn, this information is used to ensure excellent patient care, optimal reimbursement, and high compliance standards. As a recent article in *Healthcare Financial Management* accurately pointed out, "physicians . . . represent hospitals' most significant opportunity to increase charge capture, ensure accurate reflection of patient severity level, and provide adequate audit defense" (Richter, Sheldon, and Yu 2007).

CLINICAL DOCUMENTATION ARCHITECTURE FOR COMMON DOCUMENT TYPES

The Clinical Documentation Architecture for Common Document Types (CDA4CDT) is a recently formed initiative that aims to establish a guideline for creating and reporting dictated clinical information, such as operative and procedure reports, discharge summaries, and histories and physicals. Before the CDA4CDT project, no standard for such documents existed, as each type of documentation uses specific methodology to capture required data. In addition, healthcare organizations also have differing methods or processes for capturing clinical information. According to PR Newswire (2007), the CDA4CDT committee "is currently developing an 'Implementation Guide' for history and physical reports. The guide will be compatible and consistent with existing standards, such as Clinical Document Architecture, Continuity of Care Document and Logical Observation Identifiers Names and Codes (LOINC), [which are] already adopted by some healthcare facilities."

EMERGING DOCUMENTATION SYSTEMS

A number of clinical documentation companies have figured out how to directly engage the physician and capture critical information at the same time. The technology provides physicians a fast, easy, stable, and flexible way of documentation and offers management a mechanism for guiding usage and even electronically dialoguing with physicians in a customized and personalized manner. Data collected directly from this technology are structured, and this standardized format ranks high on the data-integrity scale and allows access for the purposes of tracking, trending, and clinical analysis. Unlike traditional data-capture methods, this new mechanism provides opportunities for searching, capturing, and reporting data. It also optimizes the revenue cycle management process.

At least one company offers technology that directly engages physicians with a touch-screen workstation. The software guides and dialogues with the physician, a feature that is not available with traditional, monologue, dictation-based documentation systems. Such a system is proving especially effective in the collection of objective information, such as surgical, procedural, laboratory, and imaging reports. For subjective documentation needs, "front-end voice recognition" allows physicians to enter information into a structured data-centric format.

CONCLUSION

As mentioned in the first installment of this column, successful implementation of any type of technology is not possible if its developers and users do not have comprehensive insight into its capabilities and limitations. Healthcare leaders not only must support the adoption of technologies that make processes more efficient, but they also must be proactive in such efforts. They should ensure that the selected technology complements, enhances, or fills a void in existing approaches. Doing so will lead to faster user engagement, more robust benefits, and sustainability of the technology.

References

PR Newswire Association, LLC. 2007. "Setting the Standards: Spheris Joins CDA4CDT Program Designed to Create Industry-wide Standards for Interoperability in Clinical Documentation." [Online information; retrieved 10/10/07.] http://sev.prnewswire.com/health-care-hospitals/20070409/CLM12809042007-1.html.

Richter, E., A. Sheldon, and Y. Yu. 2007. "Best Practices for Improving Revenue Capture Through Documentation." *Healthcare Financial Management* 61 (6): 44–47.

For more information on the concepts in this column, please contact Ms. Thielst at cthielst@cox.net or Mr. Gardner at jgardner@logoshs.com.