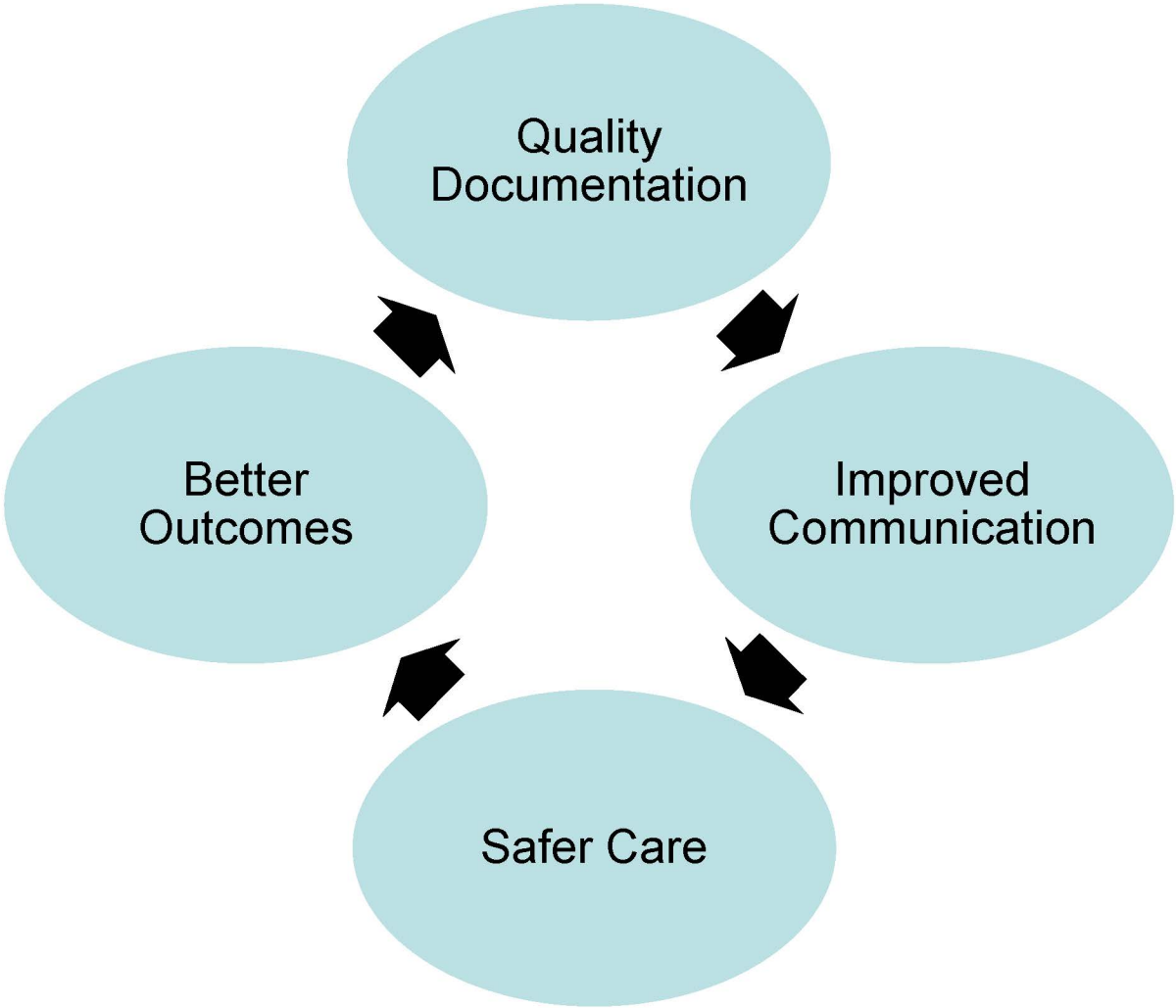
EMHS
Access to Quality Healthcare SM

Clinical Documentation

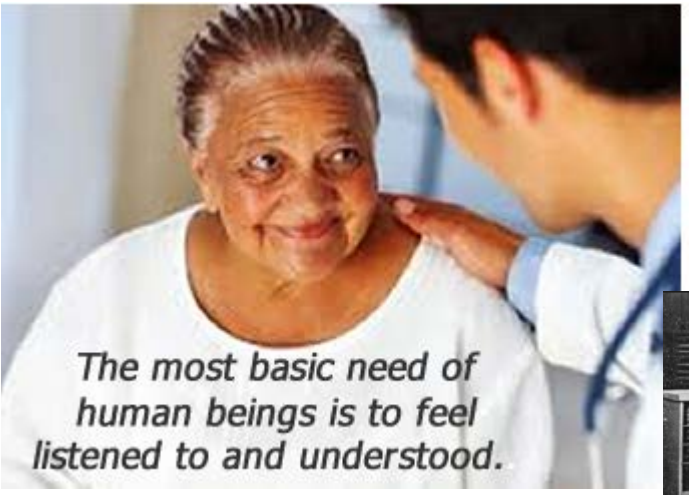
Michele R. Lauria, MD, MS
CMIO Eastern Maine Healthcare Systems

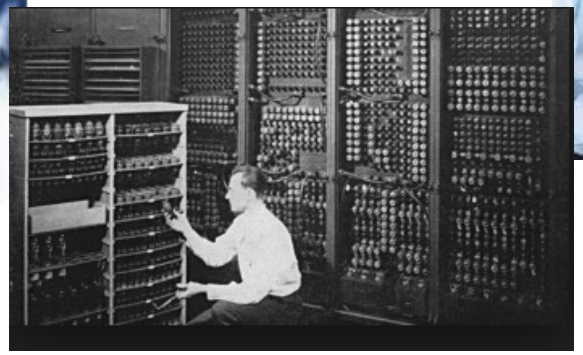
Purpose: Communicate & Record

- Condition
  - Signs, Symptoms, Diagnostic Results
- Interventions
- Responses


Quality Documentation
Improved Communication
Safer Care
Better Outcomes

Wellness





Maya Angelou

I've learned that
people will forget what you said,
people will forget what you did,
but people will never forget
how you made them feel.

Other Uses of Documentation

- Billing
- Medical Legal

EMHS
Access to Quality Healthcare SM

"There is no more difficult art to acquire than the art of observations, and for some men it is quite as difficult to record an observation in brief and plain language."
…. Sir William Osler

Factors affecting note quality

- Timeliness
- Clarity
  - Telling the story
- Synthesis of information

Timeliness

- EMR permits delays
  - Notes started during rounds
  - Completed at night
- Transcription takes time
- Availability of preliminary notes
  - Erroneous or incomplete information & plans
  - Incorrect transcriptions

Story Telling: Narrative

- Advantages
  - Descriptive
  - Synthesize especially assessment and plan
- Large unbroken blocks of text
  - Must read all parts
  - Extraneous information
- Transcription often required
  - Providers > 50 years old

Story Telling: Structured Documentation

- Small & standardized doses facilitates communication
  - Airline pilot weather report or FHRT assessment
    - Quick to document
    - Quick to review
- Check Boxes
  - HPI: Great for billing, hard to read
  - ROS & PE: “+” “-”
- Large quantities difficult to synthesize
- 13 point PE with multiple items per area
- 20 item problem list

Scroll

Codex

Scroll

MD at 07/27/12 0852

sault Note:
ission: 6/14/2012 **LOS:** LOS: 43 days
ate: 7/27/2012

ess:
in Hct, given 2U PRBC, 2FFP for INR 2.6, 1 PLT (pt 37), CRRT run 60 min, Dec Pressor

ently on epi, vtN in AM after repositioning, Levo at 40, LU cords, RU Mahuker, old lines

X year old male w/ h/o COPD originally admitted with bilateral DVTs and PE who was in the [illegible] shock, afib and GI bleed and later had a percutaneous endoscopic gastrostomy tube placed by GI on 7/13/12 who was found to have a gastric perforation and peritonitis and underwent exploratory laparotomy, lysis of adhesions, gastrotomy repair, washout and omental flap and patch admitted to the ICU for vasopressors and hemodynamic monitoring. The patient began to have an altered mental status, abdominal tenderness and abdominal distension approximately 2 days ago. CT scan revealed that the gastrostomy tube was not in the stomach and it displaced into the peritoneum. There was evidence of oral contrast within the peritoneal space as well as free intraperitoneal air with oral contrast in the peritoneum being new, compared to prior CT scan.

PMH: Benign prostatic hypertrophy, hypercholesterolemia, DVT, pulmonary embolism, aspiration pneumonia, COPD, atrial fibrillation

PAST SURGICAL HISTORY: Joint replacement of right shoulder, history of hernia repair, right humeral fracture repair, right elbow repair, tracheostomy, percutaneous endoscopic gastrostomy tube placement.

All: NKDA

Operative Summary: Date: 7/24/12
Operation: exploratory laparotomy, lysis of adhesions, gastrotomy repair, washout and omental flap and patch
Length of Operation: 2 hours
Estimated Blood Loss: 50 mL
Volume received: 1000 mL
Blood Products received: 0 mL

Past Medical & Surgical History:
History of Present Illness:

Past Medical History

Diagnosis	Date

- BPH (benign prostatic hypertrophy)
- High cholesterol
- PE (pulmonary embolism)
- Aspiration pneumonia
- COPD (chronic obstructive pulmonary disease)
- Atrial fibrillation

Past Surgical History

Procedure	Date

- Hx: orthopedics
- Hx: joint replacement
  - rgt shoulder
- Hx: hernia repair
- Hx: fracture tx
  - rgt humerus
- Hx: fracture treatment - open

Recent Labs

Basename	7/27/12 0001	7/25/12 2230	7/25/12 0050
• PROT	4.6*	3.2*	3.5*
• ALB	3.2*	1.2*	1.0*
• BILITOT	1.4*	0.4	0.3
• BILIDIR	1.0*	--	--
• BILIINDIR	0.4	--	--
• ALKPHOS	148*	121	130*
• LDH	--	--	--
• AST	17	13	19
• ALT	<10	<10	<10
• LIPASE	--	--	<10

Hematology & Infectious Disease:

No Data Recorded

CBC:

Recent Labs

Basename	7/27/12 0001	7/26/12 1745	7/26/12 1600	7/26/12 0215	7/25/12 0050
• WBC	13.5*	12.8*	13.9*	--	--
• POLY	--	--	--	84	85
• BAND	--	--	--	8	11*
• HGB	7.8*	6.1*	6.4*	--	--
• HCT	23.3*	18.2*	19.1*	--	--
• PLT	86*	57*	68*	--	--

Coags:

Recent Labs

Basename	7/27/12 0001	7/26/12 1600	7/26/12 0845
• INR	1.8	2.6	2.2
• PROTIME	20.4*	27.3*	23.6*
• PTT	42*	68*	57*
• FIBRINOGEN	--	--	--

Microbiology:

Most recent cultures reviewed.

Endocrine:

Glucose:

Recent Labs

Basename	7/27/12 0100	7/27/12 0001	7/27/12 1752	7/26/12 1600	7/26/12 1157	7/26/12 0845	7/26/12 0831	7/26/12 0215	7/26/12 0021	7/25/12 2230	7/25/12 1000
• GLUC	--	55*	--	129*	--	187*	--	158*	--	155*	146*
• GLUCOSEPOC	105*	66*	201*	--	251*	--	176*	--	190*	--	--

No results found for this basename: HGBA1C

Inpatient Medications Summary:

CONTINUOUS

PLAN:
NEURO: post-operative analgesia - fentyl gtt
CV: hypotension/sepsis - continue levophed, [illegible]
RESP: respiratory failure - continue vent mgt, pulm toilet, wean
GI: NPO; Malnutrition- begin TF vs TPN
RENAL: AKI/ATN: Poor UOP, On CRRT -50
HEM/ID: Peritonitis/sepsis s/p washout - WBC 16->23->20->13, on broad spectrum abx, f/u cultures, taper steroids; Coagulopathy: INR 2.0 >2.3 >2.6 >1.8 after 2 U FFP, transfuse prn; Acute Blood Loss Anemia 2U PRBC given with respons Hct 18->23, Transfuse prn and monitor Hh; Thrombocytopenia - transfuse plt prn (give 1plt o/n c good response)
ENDO: BS normal - continue SSI
DISPO: Cont ICU Care; CC RU Mahukur

Author: Christos Colovos , 7/27/2012 , 5:58 AM

SICU Attending Addendum

The patient was seen and examined with the SICU resident and fellow team and I spent 35 minutes of critical care time, in addition to procedures, treating this patient.

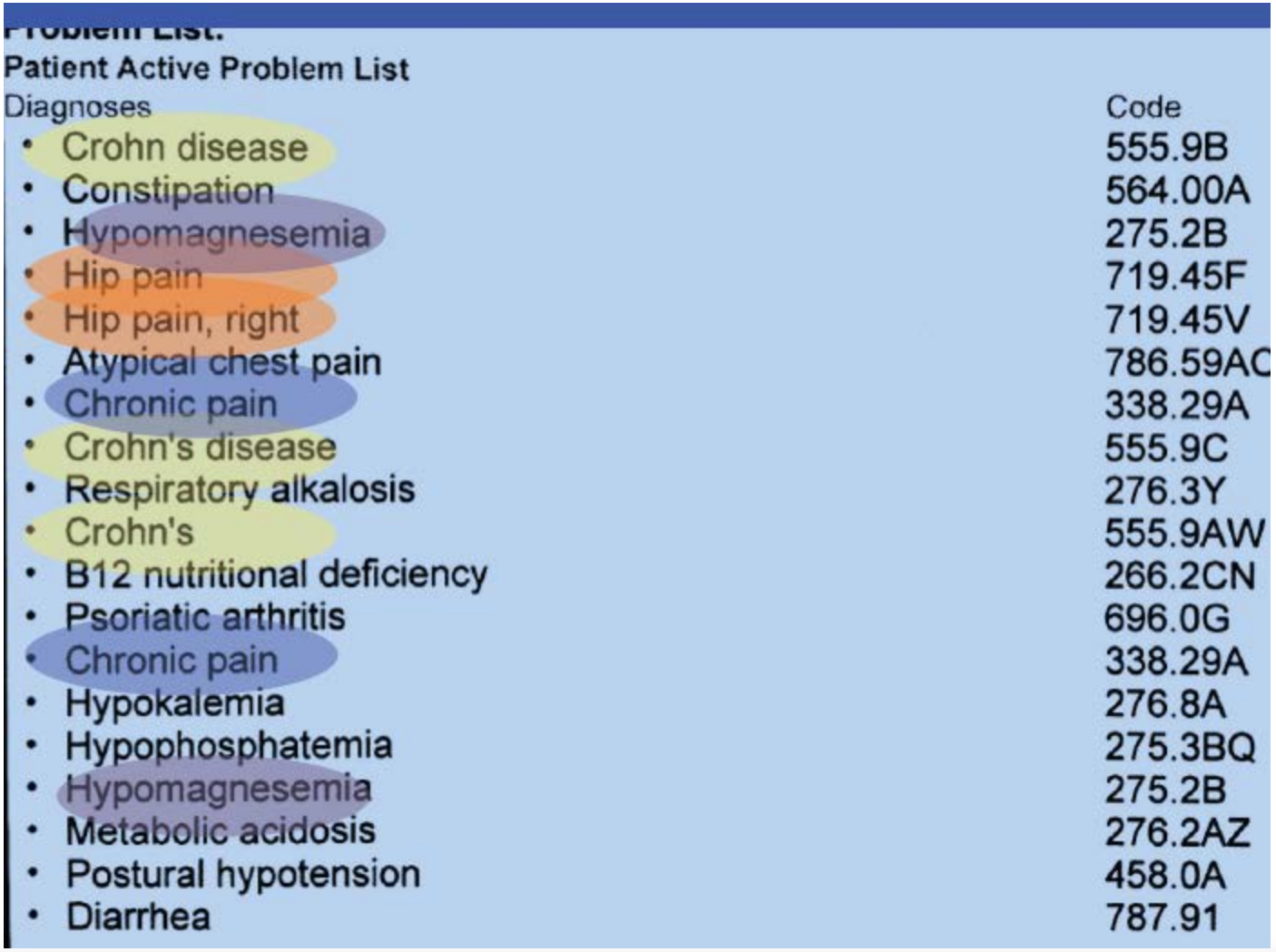
Hypervolemic, cont CRRT. During previous day unable to remove fluid. Better success overnight. CVP decreased, pressor decreased. BNP 1550.
AFib this am Amiodarone. Lovo 2
Discuss TF v TPN

HCT 23, transfuse prbc

Respiratory failure requiring ongoing mechanical ventilation.
Analyzing the patient's respiratory parameters
Adjusting the mechanical ventilatory settings
Deciding to continue mechanical ventilatory support
Deciding to continue intensive respiratory therapy

Synthesis of information

- Is NOT 5 pages of labs/rads or all meds
- Typically requires prose
  - Why is this the diagnosis?
  - Where others considered?
  - Current plans and alternatives
  - Counseling
- HCC & Preventive Care
  - May make synthesis difficult



Problem List:

Patient Active Problem List

Diagnoses	Code
• Crohn disease	555.9B
• Constipation	564.00A
• Hypomagnesemia	275.2B
• Hip pain	719.45F
• Hip pain, right	719.45V
• Atypical chest pain	786.59AC
• Chronic pain	338.29A
• Crohn's disease	555.9C
• Respiratory alkalosis	276.3Y
• Crohn's	555.9AW
• B12 nutritional deficiency	266.2CN
• Psoriatic arthritis	696.0G
• Chronic pain	338.29A
• Hypokalemia	276.8A
• Hypophosphatemia	275.3BQ
• Hypomagnesemia	275.2B
• Metabolic acidosis	276.2AZ
• Postural hypotension	458.0A
• Diarrhea	787.91

Communication Efficiencies

- Encounter Summaries vs Notes
  - Document histories as reviewed, no need to populate into notes
  - Useful if on same EMR
  - Notes focused on Assessment and Plan
- APSO
  - Allows supporting evidence to be at end of note
- Double Column
- Pictures

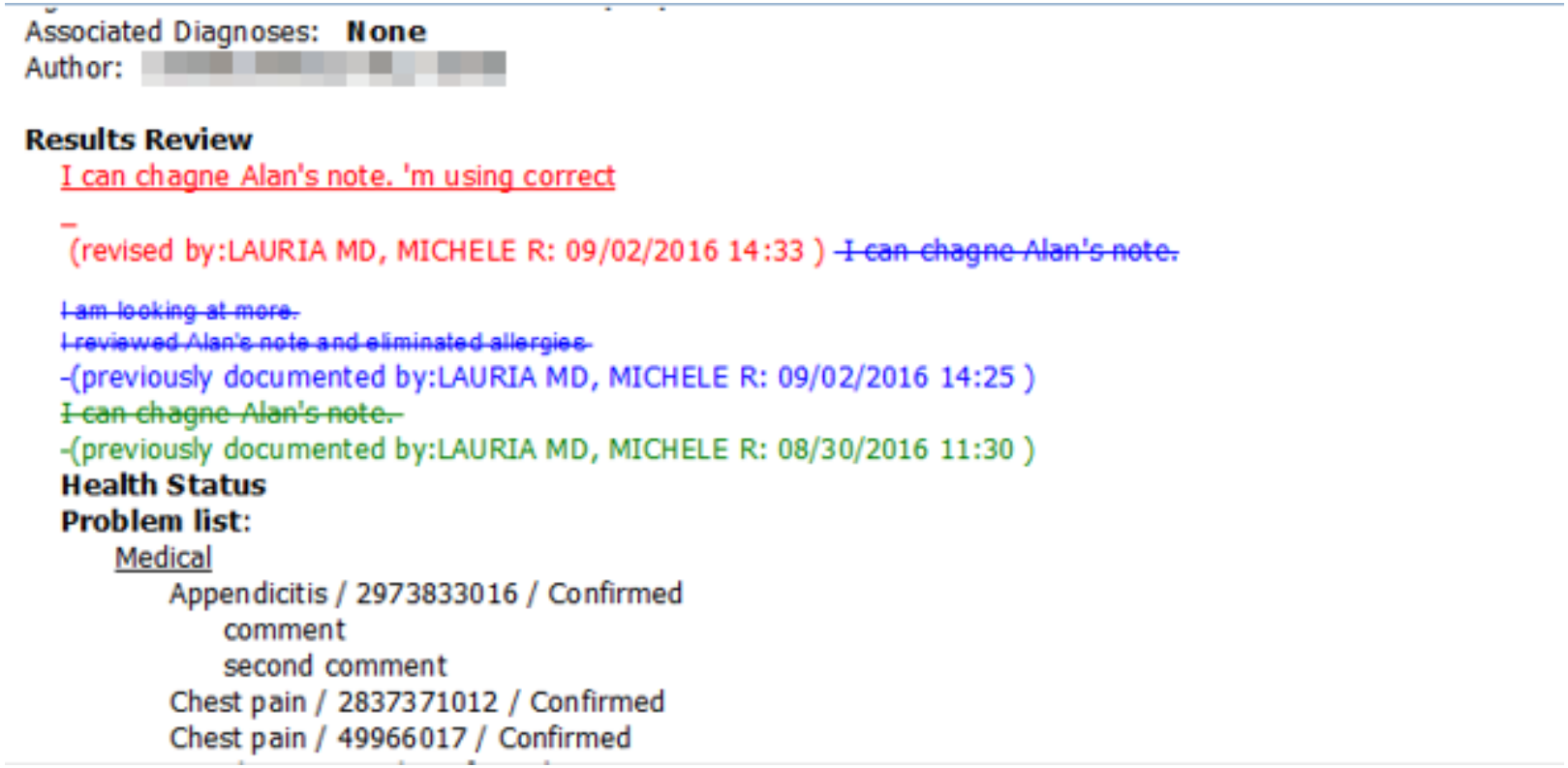
Copy & Paste; Copy Forward

- Modify to reflect current condition and plans
- Advantages
  - Easier to identify changes
  - Saves Time
  - Minimizes risk of forgetting important issues
- Disadvantages
  - Propagation of erroneous information
  - Failure to update destroys the story
  - Note bloat
- Considerations
  - Attribution to original author
  - Color coding when not changed
  - How much change is needed before it is considered original

Note Correction vs Addendum

- Correction: within body of note
  - Ideal for fixing erroneous information
- Addendum: at end of note
  - Ideal for updating course
- Considerations
  - Restrict to note author?
    - Meta data changes, i.e. author, filing date
  - Display in active note
  - Audit trails
  - Forensic ROI

Maximal Tracking



Associated Diagnoses: **None**
Author: [redacted]

Results Review

I can chagne Alan's note. 'm using correct

(revised by:LAURIA MD, MICHELE R: 09/02/2016 14:33) ~~I can chagne Alan's note.~~

~~I am looking at more.~~
~~I reviewed Alan's note and eliminated allergies~~
-(previously documented by:LAURIA MD, MICHELE R: 09/02/2016 14:25)
~~I can chagne Alan's note.~~
-(previously documented by:LAURIA MD, MICHELE R: 08/30/2016 11:30)

Health Status

Problem list:

Medical

Appendicitis / 2973833016 / Confirmed
comment
second comment
Chest pain / 2837371012 / Confirmed
Chest pain / 49966017 / Confirmed

Forensic ROI issues

- Patient vs Encounter specific information
  - Information at time of visit
- Full audit of all changes with attribution printed on notes
- Sequencing knowledge acquisition
  - Faxed records
- Printed vs computer formats
  - Orders
  - Nursing documentation

Note Quality Feedback

- Typically lacking until trouble arises
  - Peer feedback rare
  - Native EMR tools lacking
- Coders often discover issues
- Possible Benefits
  - Refresher training in EMR tools
  - Mentoring
  - Requires a CMO willing to act

Progress Note Evaluation

YES NO NO: Partially Copied NO Fully Copied.

- Vitals: non-cluttered, only ranges or pertinent values
- Newly Written
  - Subjective
  - Physical
  - Assessment & Plan
- New findings and plans are clearly evident
- Internal discrepancies present/absent
- Lab and imaging section non-cluttered, only pertinent results and interpretation
- Synthesis of information into appropriate diff diagnosis
- Comments

EMHS
Access to Quality Healthcare SM

"The value of experience is not in seeing much but in seeing wisely."
…. Sir William Osler