Spectrum Health Clinician-Created Document Integrity Program

Spectrum Health is the largest, not-for-profit integrated healthcare delivery system in West Michigan. It is comprised of 12 hospitals, 2000+ beds, and 180 ambulatory/service sites. Priority Health is their nationally recognized health plan with greater than 750,000 members. Spectrum Health is the largest employer in West Michigan with 25,300 employees, 1600+ physicians/APPs, and 1600 independent physicians.

Clinicians at Spectrum Health began using an EHR to create inpatient progress notes in 2013 and the HIM Document Integrity program was born. Initially, one transcription QA specialist was tasked with reviewing those progress notes for quality purposes. It was immediately apparent that if the trend toward clinician-created documentation was to continue, review of those documents would be critical to ensuring medical record integrity. Thankfully, Spectrum Health's Director of HIM/Document Integrity was, and continues to be, a strong proponent of the work being done. He champions the need for identifying critical errors in clinician-created documents (those that have the potential to impact patient care) and correcting/amending as needed. Educational opportunities for clinicians are also identified and can be addressed. The HIM Document Integrity program focuses on patient safety and quality within the content of the document. Their CDI program ensures an appropriate level of documentation to best represent SOI (Severity of Illness) and ROM (Risk of Mortality) from a coding perspective. Their Director is quoted as saying, "Coupled together, these two processes cover all angles needed to ensure quality documentation" for the patients of Spectrum Health.

It was only a matter of time before clinicians started documenting far more than just those initial progress notes and soon the assistance of about five transcriptionists was needed. At the time Spectrum Health began this work, there were no other programs like it. There were no industry best practices for them to refer to. Leadership jumped at the opportunity to work with AHDI, AHIMA, and others in the industry to create a toolkit for facilities looking to initiate clinician-created document integrity programs. The toolkit as it exists today includes some of the spreadsheets, etc. that Spectrum used at the outset. The program has since evolved and become far more automated, allowing them to focus on the findings of document review rather than the process itself which was initially very time consuming.

A report was created in the EHR that allowed the Document Integrity team to run a list of all clinician-created documents created on a given day within the EHR. Once generated, the list was filtered to only include those work types to be audited (pathology, radiology, etc., were not included as they did not fall under HIM originally). From there, the list was then broken up for multiple auditors to claim and work on a daily basis. Each list had approximately 30 documents on it. The documents were located within the EHR, copied/pasted into a Word document, and the audit begun. A detailed system of highlighting along with standard auto corrects were the basis for the audit process. Each error type had to be manually tabulated and an embedded spreadsheet within the Word document allowed them to reflect the # of errors (critical and noncritical) contained within the document. Information from these individual spreadsheets had to be manually copied and pasted into provider-specific spreadsheets that were created for reporting purposes. A final compilation spreadsheet was created that linked to each of those individual spreadsheets. This was extremely time consuming as it sometimes took over 10 minutes to open this final compilation spreadsheet once linked to over 1500 providers.

With the implementation of a QA audit tool, Spectrum has automated the data collection piece of the process thereby saving considerable time and resources. Lists are still created of all clinician-created

documents and broken down for auditors to claim and work. Auditors copy the document from the EHR directly into the QA audit tool where they continue to use the highlighting/autocorrect system to identify all errors found. The QA audit tool automatically tabulates the errors and builds and maintains the database which allows for efficient and robust reporting capabilities.

As critical errors with the potential to impact patient care are discovered in documents, they are reported by the auditor using a system of flags which are monitored daily. In most instances, the provider is asked to add a clarifying addendum to the original document. In some instances, however, the error requires that the document be placed "In Error" and completely recreated. The Document Integrity staff assists clinicians in this process. Some errors are considered to be critical but do not necessarily impact patient care and are therefore not corrected (i.e. Joint Commission Do Not Use Abbreviations). These errors continue to be noted and tracked for education and reporting purposes. Noncritical errors such as spelling, grammar, punctuation and others that compromise the integrity of the document are noted and tracked for informational, and potentially educational purposes as needed.

Results are published quarterly and shared with upper management. With the QA audit tool, they have the ability to look at any given provider and identify problem areas in documentation. They can also look at individual error types and identify providers struggling the most with that specific error. Alternately, they can look at providers whose documentation is of the highest quality and deserving of recognition. With THE QA audit tool, they also can look at data per *auditor*. It is possible to see which auditors are identifying which kinds of errors the most, or least; which auditors identify the highest number of *critical* (or noncritical) errors, etc.

Over the years, Spectrum Health transitioned 5-6 of their healthcare documentation specialists at a time over to the document integrity team where they began auditing. This had to be done without impacting the transcription team's ability to meet turnaround times on the significant dictation volume they still had. It was initially assumed that the HDSs transcription experience could potentially limit their auditing ability, i.e. ability to audit operative notes if they were never transcribed. Spectrum Health has found this NOT to be the case in most instances. The leadership team looked for HDSs who expressed a desire to transition and had the technical skills necessary as auditing required more of them technically. Fully aware of where the industry was headed, most HDSs saw this as an opportunity to grow their skills and strengthen job security. As with any change, the transition for them was met with anxiety and uncertainty as they questioned whether they would get the same sense of satisfaction out of retrospectively auditing clinician-created documents (without the benefit of a voice file) versus being a more active participant in the document creation process through traditional transcription/editing. The adjustment was substantial considering the different quality standard a clinician-created document is held to versus documents created by professional documentation specialists. Once the transition period ended, most auditors at Spectrum Health would tell you that they prefer auditing clinician-created documents and wouldn't want to go back to transcribing/editing!

Integral to the success of their Document Integrity program was the development of a senior or lead analyst who oversees the day-to-day operations as well as the data management within the QA audit tool. One Training and Development Specialist focuses on training of new auditors, including all supporting documentation as well as development of a formal mentoring program. This person is also responsible for the ongoing training of all auditors as well as annual competency evaluations. Another Training and Development Specialist focuses on resource development and maintenance. A comprehensive Marking Manual has been developed (over 350 pages) that includes explanations of all

error types as well as examples. This is an ever-changing resource and often requires updating and re-education.

Spectrum Health has structured their Document Integrity program very similarly to their Transcription program. They have begun to monitor production and will have production goals. They have begun to monitor quality and will have quality goals. They will also continue to require continuing education and are heading toward required AHDI credentialing.

Developing a program such as this has been challenging, but extremely rewarding. With the support of their senior leadership, they continue their quest to ensure the highest quality documentation for the patients of Spectrum Health. The team is now focused on adapting their current EHR-based program to becoming a program in our new EHR system so the learning and development continue on!

Sheila Guston, CHDS, AHDI-F
Manager, Healthcare Documentation Integrity
Spectrum Health