EHR Support for Provider Coding

- Highlight key considerations that need to be taken into account when developing Ambulatory physician workflows using an integrated electronic medical record and billing systems to support coding/charge capture processes.

- Understanding workflow implications, as well as user acceptance is critical to ensuring efficiency, adherence and compliance.
Today’s Discussion

- Introduce Kaiser Permanente and our electronic health record (EHR)
- Highlight EHR benefits
- Discuss End User Perceptions
- Review Common Challenges
- Discuss advantages of EHR to support coding
- Eliminating Unnecessary Documentation
- Reinforcing Key Workflow Steps
- Demonstrate electronic coding support tools
- Key Take-Away’s

Who are we?

- Kaiser Permanente HealthConnect® with care team adoption in all of its 36 hospitals and 431 medical offices.
- KP HealthConnect is the world’s largest privately owned electronic health record, securely connecting more than 8.6 million patients to their physicians, nurses, and pharmacists, personal information, and the latest medical knowledge.
Electronic Health Records (EHR) Benefits

- Eliminates legibility issues
- Streamlines and facilitates the documentation processes
- Provides immediate access to all pertinent patient data
- Leads to improved patient quality and safety outcomes
- Promotes continuity of care and data integrity
- Increases communication between the patient and the care delivery team
- Integrates charge capture processes (i.e., scheduling, registration, documenting, coding, billing)
  - Allows for Charge Master Files
  - Electronic Data Capture directly from documentation workflows
- Serves as a rich data source for research and development

End User Perceptions

- Chaos to Nirvana?
- More work with little yield?
- Ease of locating patient data
- One stop shopping
- Patient’s access to “MyHealth” Record
- Ability to communicate with patients over secure messaging
- Seamless and integrated provider schedules, coding and billing processes
- More complex workflows
- Too many clicks!
- Upgrade interruptions
- New enhancements and functionality – more training
Common EHR Challenges

User acceptance
- Evolving and ongoing process
- Requires strong sponsorship from top level down
- Highlight positive outcomes “What’s in it for me”?
- Requires adequate onsite resources for go-live and post go-live support

Impact on day-to-day workflows
- Documenting the care during the patient encounter or immediately afterward?
- Are there other care providers who can “stage” components of the encounter?
- How do you handle future standing orders?
- Creating encounters on the “fly”
- “If you are not documenting real time, you are documenting on your own time”
  - Takes skill to balance patient interaction with exam room computer

Common EHR Challenges (cont’d)

Impact on day-to-day workflows
- What about diagnosis association?
- Is there a close visit (soft or hard-stop) validation?
- How do we capture the Supervising Provider for billing?
- Service performed today; supervision/interpretation and report is completed on a different date of service
- Are there ways to take short-cuts?
- How can we reducing the number of “clicks”?
- How do we avoid “alert” fatigue?
From 0-5,000+ in 1 year!

- Need to accurately and comprehensively bill for services
  - Revenue
  - Service comparison for employer choice
  - Tracking work performed
- Mandate doctors to code?
  - Joined KP to avoid business
  - Accuracy would be low, even with vendor’s “Wizard”
- Solution:
  - Train doctors in basics of coding for given department
  - Electronic support using coding knowledge

Changing Direction
What We’ve Done

- 5000+ doctors trained
- Electronic coding support
  - PMFSH, Data Review
  - Worksheet for non-electronically capture data
  - Chronic Disease Form
  - Compound Codes
  - Orders Diagnosis Association Display
  - Natural Language Processing (NLP)
  - Query Tool
  - Scrubbers!
- Coders & Auditors did not go away!

Coding Panacea?

Not quite: The EHR does carry some baggage.
Dirty Data: Avoiding Unnecessary Documentation

- Dirty Data
  - Unclean problem lists
  - Unclean Medication lists
  - Wrong primary diagnosis entry
  - Unedited templates
  - Use of “copy previous note”
  - Wrong visit information

- More documentation does **not** necessarily result in a higher E&M score
  - Unnecessary documentation clutters progress notes
  - Unnecessary documentation makes note review more difficult

The length of the note does not drive the E&M code
Types of EHR Derived “Dirty Data”

- Documentation enhancing E&M coding, but not medically necessary
  - Not unique to EHR, but much easier to accomplish
- Primary diagnosis not identified correctly
- Links to automatically load data to documentation
  - Efficient, but oftentimes inaccurate
- Copy prior note functionality
- Templates used, not edited for current visit
- HPI not by physician or Non-Physician Provider
- Staging of orders/codes useful, but needs careful review
- Inaccurate Visit Information selected
- *All may result in audit vulnerabilities

Reinforcing Key Workflow Steps

“Dirty Data” – Inaccurate visit information

- Selecting the wrong “visit type” can corrupt the E&M score
- Common errors in visit type selection include:
  - Not changing office visit to Preventive Service
  - Not selecting “New” vs. “Established” for Preventive Services
  - Not changing the default from established to new patient as appropriate

- Developing templates to support compliant charge capture
Ambulatory Coding Query Tool

- Efficient for a single coding auditor to reach many physicians
- Provides communication vehicle to clarify conflicting or misleading documentation
- Rules surrounding coding queries
  - Types of queries that can be done
  - Response timelines
- Auditor and Physician response?

Demonstration
Electronic Coding Support
Optimizing Performance

- Analyzing end user workflows and documentation behavior
- Evaluating options to streamline processes
- Utilizing audit results to identify “gaps”
  - Example: Discovered CC often missing in notes since nurse enters in separate area of EHR
- Reinforcing specific features
- Identifying “primary” diagnosis

Key Take-Away’s

- Be prepared to anticipate anything - “If it can be done it will be done”
- Develop workflows to support compliant behaviors
- Refine training approaches to adapt to evolving user acceptance and learning curves
- Utilize “lessons” learned to improve future processes
- Analyze audit findings to assist with “gap” identification
- Modify audit plan and focus areas
- Integrate clinical quality with documentation and coding integrity
Questions…