Chartcraft: Improving Documentation with Peer Coaching and On-Line Chart Review

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Chartcraft: Improving Documentation with Peer Coaching and On-Line Chart Review

Learning Objectives

- Understand the history and role of peer review in provider assessment
- Understand the concept of “Chartcraft” and its importance in peer coaching
- Understand the burden that results from poor clinical documentation technique
- Identify a peer coaching program centered on applying Chartcraft principles to improve documentation content and technique
- Identify an online tool that can be used to improve assessment and peer coaching of Chartcraft
Acknowledgements

• Tim Ferris, MD, MPH
  • Chief Executive Officer, Massachusetts General Physicians Organization

• Sandhya K. Rao, MD
  • Assoc. Medical Director Quality, Massachusetts General Physicians Organization

• Keith Jennings,
  • Chief Information Officer, Massachusetts General Hospital

• Michael Peer
  • Data Analyst, Massachusetts General Physicians Organization and Mass General Hospital for Children

• Partners Healthcare Information Systems:
  • Adam Bensle, Chris Fusco, Sally Grindal, Bob Wheeler
Physician Performance Assessment: Past

- **Physicians / Groups:** Professional self-regulation
  - Credentialing / Re-Credentialing
  - Privileging

- **Hospital Accreditation Bodies:** Protect patients
  - CME Requirements

- **Payer Credentialing:**

- **Payers:** Attract and protect consumers
  - CRICO/RMF Requirements

- **Specialty Boards:** Professional self-regulation
  - Board of Registration in Medicine
    - Protect public from harm
  - Board Exams

- **Professional self-regulation**
Physician Performance Assessment: Today

**Physicians / Groups:**
Professional self-regulation

- MGPO QI Program
- Dept / Group Quality Efforts
- Care Redesign
- Credentialing / Re-Credentialing
- Privileging
- OPPE / FPPE
- IPF/ACO Measures
- Payer Credentialing
- Meaningful Use
- Maintenance of Certification
- CRICO/RMF Requirements
- Board Exams

**Payers:**
Attract and protect consumers

- IPF/ACO Measures
- Payer Credentialing
- Meaningful Use

**Hospital Accreditation Bodies:**
Protect patients

- Hospital Accreditation Bodies
- Protect patients

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Protect public from harm

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**Specialty Boards:**
Professional self-regulation

- Specialty Boards
- Professional self-regulation

- Board Exams
- CME Requirements
- CRICO/RMF Requirements
- CRICO/RMF Requirements
Physician Performance Vision:
Quality Improvement Initiatives Satisfy Multiple Requirements

- IPF Measures
- MGPO QI Program
- Care Redesign
- OPPE/FPPE
- Dept/Group Quality Efforts
- Maintenance of Certification
- CME Requirements
Why Peer Review?

• Historically, peer review was a quality assurance function, aimed at **reviewing adverse outcomes**

• Evaluation is shifting toward greater focus on systems-focused, data driven **process improvement**

• With increasing **team based and shared care** – quality of colleagues and consistency of practice is more important

• **Challenge**: how to capture aspects of care that are not assessed by existing clinical performance measures.

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Mass Medical Survey (2010)

‘Alternatives to evaluating physician competency’

MD responses:

• Review by peers or fellow MDs (75%)
• Chart review of office based records (74%)
• Chart review of inpatient records (72%)
• Specialty/board recertification (67%).
Well-crafted clinical documentation is more important than ever…

• Increasing number of handoffs demands better coordination of care, and clinicians’ notes remain a critical method of communication between care providers
• The purposes of clinical documentation extend beyond logging the patient’s clinical progress and includes achieving quality measures, firing clinical decision support, satisfying payer requirements, meeting risk-management points, &c.
• The consumers of clinical documentation extend well beyond the provider, and includes the care team, payers, regulators, and the patients themselves
...yet poor documentation still prevails

Most ambulatory provider documentation is written with a paper-based paradigm in mind. And providers have not been coached in the most up-to-date standards of optimum content and technique of crafting an efficient, thorough, clear note that communicates well to the chart consumers. As a result:

• There is little standardization in the way providers write notes
• Most notes are bloated with unnecessary information that can be found elsewhere in the electronic record
• Because of note bloat and poor organization, important clinical facts, medical decision making, and care plans are tedious to locate and read
• Poor note organization and content also reflects inefficient note crafting, resulting in burden on the part of the note author
“Physician burnout rates range from 30-65% across medical specialties, with the highest rates experienced by those at the front line of care.”

Arch Intern Med. 2012;172(18):1377–85
Mayo CLIN Proc. 2015; 90(12):1600-1613
Physician challenges with transition to the EHR

Physician Effort (1965)

- Hands on Patient
- Documentation
- Cash Billing

Physician Effort (2018)

- Hands on Patient
- Documentation
- Charge Capture
- Results Management
- Inbox Management
- Med-Rec
- Population Health Mgmt
- Order Entry
- Mandatory Training
- Pay-for-Performance
- Patient Portal
- e-Prescribing
- Referral Mgmt
- Registry Reporting

Source: Dr. James McFarland, MGH Cardiologist
CRICO/RMF Grant for Documentation Improvement

PROJECT AIMS:
• Create a contemporary model for peer review – efficient, EMR based, measurable
• Evaluate the impact of a collaborative educational experience on key aspects of clinical documentation
• Create quantified physician performance data for the JC OPPE requirement and ABMS MOC Part IV requirement
• Expand this program across our institution as the standard for new physician FPPE and OPPE where appropriate
• Expand its use to additional care settings, specifically discharge summaries and other high-risk transitions of care

Overall Requirements for Participation
• Complete a pre survey about documentation (today’s task)
• Review 10 charts peer charts in the On-Line Chart Review Program (approximately 1 hour)
• Participate in educational intervention (approximately 30 minute webinar via HealthStream)
• Meet with coach at least once (1-2 hrs.) and develop an action plan
• Focus on improving documentation while working
• Review 10 charts to measure outcomes (approximately 1 hour)
• Complete post-survey about the experience
Mindmap of Optimum Charting

*Massachusetts General Physicians Organization 2015

**Technique**
- Efficient Practice
- Timely, Patient Centered, Safe

**Content**
- Complete
- Compliant
- Useful

**Optimum Charting**
- Goal: a clinically useful, efficiently documented encounter

**Mindmap of Optimum Charting**
- **“Do Today’s Work - Today”**
- **“Do It Just in Time”**
- **“Leverage the Right Participants”**
- **“Use the Right Tools”**
- Voice Recognition
  - Scripts
  - Smart Text
  - Templates

**“Be Parsimonious”**
- Avoid copy-paste of irrelevant old data
- Leave EHR Speak for itself

**“Be Thorough”**
- Avoid copying labs
- Avoid copying meds, allergies, problems, vitals, etc

**“Be Useful” - is the note advancing Patient care?**

**Equipment**
- Laptop/Tablet/PC as appropriate to setting
- Proper position of equipment
- Microphones for voice recognition

**Patients**
- Nurses, MAs
- Rendering Provider
- Trainees
- Central Data Entry

**Orders**
- Last Note
- Last Visit
- Latest Labs
- Medications
- Core Reminders/Alerts
- Personal Details

**POC**
- FAM
- Imaging
- Labs
- Referrals
- Procedures

**Avoiding the Chart**
- Avoid Pre-Charting
- Avoid Opening Charts until Needed

**Avoiding the Chart**
- Providing the Chart
- Data Gathering During Visit
- Ordering in the Exam Room

**“Be Efficient”**
- Communicate to Self
- Communicate to Care Team
- Communicate with the Patient
- Problem-Oriented Charting
- Add to the “team approach” e.g., place data in coded fields to aid decision support
Demographics

• 5 Coaches
  • Primary Care providers
  • Epic Super Users
  • Trained peer coaches
• 56 participants *
  • Volunteers responded to an open invitation

• Majority 6-9 sessions per week
• 79% with 7-10 patients/session
• 17% with more than 10 patients/session
• < 60% routinely find practice moderately to severely stressful
• Desire to improve speed
• Increase efficiency in problem oriented charting, orders and order sets, In-basket, Medication reconciliation, etc.

*7 dropped out due to time constraints
Pre Measures
Initial Peer Chart Review

• The participants were randomized to review 10 notes from other participants in the project.
• Notes reviewed were scored on the clarity, completeness, and relevance of the documentation.
• Pre-assessment 10 charts were reviewed
• Post assessment 5 charts were reviewed for each participant.
Peer Comments from Initial Chart Review

- Don't need to list meds and problems in the note because they are in the encounter
- Flood of information, mostly duplicative and irrelevant and key issues buried under administrative stuff.
- Missing Overview
- I am left unsure what happened and what the plan is, exam/history/data all mixed up
- I don't see any history about the patient, problem list, or management... the patient's BP is high and that is not mentioned.
- It would be nice to use a template with less duplication - e.g. social history twice. Problems listed 3 x - once in diagnoses, once in problem oriented note, and in the problem list at the end
- Might be helpful to have one summary statement in the Assessment, such as "Healthy --yo woman, normal exam, no current medical issues (or no current medical issues but with + fmxh DM). Otherwise, great note!"
Video on Chartcraft

- 30 minute video
- Introduces the Chartcraft concept
- Participants demonstrated understanding in the Knowledge Check:
  - 95% knew that “pre-charting” was not a best practice in Epic
  - Most documentation activities can be completed with the patient in the exam room (activating problems/adding problems, writing orders, associating orders/medications with diagnoses for billing, signing orders)
Coaching

- Each participant was matched with a peer coach
- Coach meetings were between 1 and 2 hours long and occurred after the participants completed the pre-survey, initial chart review, and eLearning activity
- Coaches received the pre-survey responses and initial chart review reports for their participants to help guide see where the participant may be struggling and how best to focus the impact of the session.
- Participants completed a template action plan after the session
Preliminary Feedback and Tips from Coaching Sessions

Tips from Action Plans/Coaching Follow-up

• Moved to the “three panel view” in the Plan section during an encounter to demonstrate work in a problem-oriented charting fashion, while having access to your Orders and Notes, all in one view
• Built a more appropriate visit note template for you to use during encounters
• Try out Encounter as your first stop instead of Notes to review other visits
• Remove some sections such as Meds and Family History that will already be present for anyone looking at the Encounter
• Take a look at Snapshot before you go into the room
• Re-arranged the sections you use frequently so there is less need to scroll
• Move to documenting the history plus assessment and plan all under the Problem and then put .probap at the top of your note.
Outcomes: One Month Post-Coaching Meeting

Wave 1 Pre Intervention | Wave 1 Post Intervention
---|---
Clarity | Completeness | Relevance
Overall Assessment | Overall Score

Wave 2 Pre Intervention | Wave 2 Post Intervention
---|---
Clarity | Completeness | Relevance
Overall Assessment | Overall Score
Self-Reported Outcomes:

- Pre-Intervention 75% of participants said they ALWAYS spent time after their clinic session documenting.
- Post-Survey only 50% of the participants reported ALWAYS spending time after clinic completing their notes.
- Data shows that the amount of time after clinic spent documenting was reduced.
  - Respondents who spend more than 90 minutes after their clinic session documenting dropped from 34.5% to 27.8%
  - 11% individuals responded that they spent less than 30 minutes after sessions documenting (an increase of 7.7% from the pre-survey.)
Self-Reported Outcomes (cont’d)

- Difficulty locating information in the EHR:
  - Pre-program: 36%
  - Post-Program: 31%

- Work efficiently in the EHR
  - Pre-program: 34%
  - Post-program 64% in the post survey

<table>
<thead>
<tr>
<th>Statement</th>
<th>Always</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
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<tr>
<td>I feel that this program has improved the QUALITY of my documentation</td>
<td>10%</td>
<td>35%</td>
<td>45%</td>
<td>10%</td>
<td>0</td>
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<tr>
<td>I feel this program has improved the efficiency of my documentation</td>
<td>5%</td>
<td>55%</td>
<td>40%</td>
<td>0</td>
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<td>Working with a peer coach was beneficial</td>
<td>55%</td>
<td>35%</td>
<td>10%</td>
<td>0</td>
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<tr>
<td>The on-line chart review portion of the program was valuable</td>
<td>10%</td>
<td>35%</td>
<td>45%</td>
<td>10%</td>
<td>0</td>
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<tr>
<td>The e-Learning module on HealthStream was helpful</td>
<td>15%</td>
<td>30%</td>
<td>50%</td>
<td>5%</td>
<td></td>
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<tr>
<td>This program was a good use of time</td>
<td>40%</td>
<td>40%</td>
<td>20%</td>
<td></td>
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<tr>
<td>I would recommend this program to others</td>
<td>40%</td>
<td>50%</td>
<td>10%</td>
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</table>
MGPO On-Line Peer Chart Review Tool
MGPO Peer Chart Review Program

- Partners HealthCare web application
- Live calls Clinical Document Repository
- Clinicians review each others documentation on-line
  - Practice determines peer review structure (random/matched)
  - Practice determines survey questions and scoring
    - Questions are placed in categories (Completeness, Clarity, etc.)
    - Category scores are used to measure change and to set thresholds for OPPE/FPPE
- Output:
  - Department level scores for categories
  - Individual clinician reports
Chief Complaint / HPI

Chief Complaint

f/up admit cellulitis

HPI

Admitted to CHB on 7/7 for L lateral thigh cellulitis after ?bug bite. “It kept growing and getting red and hot so I took her to ER” per mom. No fever. Admitted to CHB for IV abx and discharged on Sunday 7/8 w/ 8 more days of Keflex and Bactrim. Remarkably improved per mom.
NOTE: This tool has the ability for drill-down questions to appear depending on how you answer a question. The insert shows follow-up questions related to a “yes” answer on the survey.
Individual Physician Report

Shows individual physician performance, thresholds for focused review opportunities for individual and group-level improvement.

Threshold set for OPPE/FPPE

Links to note to compare to score
Practice Level Report Produces OPPE Data

- Department receives report with individual physician performance
- Thresholds for each measure*
- Highlights opportunities for group level improvement

<table>
<thead>
<tr>
<th>Physician Name</th>
<th># Charts Reviewed</th>
<th>Completeness Score</th>
<th>Clarity Score</th>
<th>Relevance Score</th>
<th>Overall Assessment</th>
<th>Overall Score</th>
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<td>Krakauer, Eric L</td>
<td>10</td>
<td>72%</td>
<td>74%</td>
<td>82%</td>
<td>68%</td>
<td>82%</td>
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<td>Jackson, Vicki A</td>
<td>10</td>
<td>76%</td>
<td>70%</td>
<td>64%</td>
<td>70%</td>
<td>79%</td>
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<td>Smith, Lorie N</td>
<td>10</td>
<td>79%</td>
<td>98%</td>
<td>94%</td>
<td>93%</td>
<td>94%</td>
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<td>Doyle, Kathleen P</td>
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<td>80%</td>
<td>81%</td>
<td>94%</td>
<td>74%</td>
<td>83%</td>
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<td>Kamdar, Mihir M</td>
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<td>80%</td>
<td>94%</td>
<td>88%</td>
<td>88%</td>
<td>91%</td>
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<td>Wilson, Erica J</td>
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<td>86%</td>
<td>83%</td>
<td>88%</td>
<td>69%</td>
<td>84%</td>
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<td>Doyle, Kathleen P</td>
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<td>84%</td>
<td>88%</td>
<td>89%</td>
<td>90%</td>
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<td>Kamdar, Mihir M</td>
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<td>90%</td>
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<td>80%</td>
<td>88%</td>
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<td>Jacobsen, Juliet C</td>
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<td>90%</td>
<td>94%</td>
<td>82%</td>
<td>78%</td>
<td>88%</td>
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<td>O’Brien, Karen A</td>
<td>10</td>
<td>92%</td>
<td>98%</td>
<td>88%</td>
<td>90%</td>
<td>95%</td>
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Average Scores

<table>
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<tr>
<th>Measures</th>
<th>Average</th>
<th>2 Standard Deviations</th>
<th>Threshold</th>
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<tbody>
<tr>
<td>Completeness</td>
<td>83%</td>
<td>0.125682139</td>
<td>70%</td>
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<tr>
<td>Clarity</td>
<td>87%</td>
<td>0.18616122</td>
<td>68%</td>
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<tr>
<td>Relevance</td>
<td>86%</td>
<td>0.16277592</td>
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<tr>
<td>Overall Assessment</td>
<td>80%</td>
<td>0.180986187</td>
<td>62%</td>
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<tr>
<td>Overall Score</td>
<td>87%</td>
<td>0.100478853</td>
<td>77%</td>
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*Any physician that scores 2 standard deviations below the group average is flagged for follow-up by unit chief/department head in advance of “focused review”
Adoption across MGH (< 30% of Clinician FTEs)

<table>
<thead>
<tr>
<th>Service</th>
<th>Department</th>
<th>OPPE/FPPE/Both</th>
<th>Subjects</th>
<th>Clinical Lead</th>
<th>Admin Lead</th>
<th>Threshold for Focused Review</th>
<th>#</th>
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<tbody>
<tr>
<td>DOM</td>
<td>Hospital Medicine</td>
<td>OPPE/FPPE</td>
<td>MD</td>
<td>Warren Chuang</td>
<td>Danica Mari</td>
<td>Completeness: 2 SD below mean</td>
<td>12</td>
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<tr>
<td>DOM</td>
<td>Medical Walk-in Unit</td>
<td>OPPE/FPPE</td>
<td>MD, NP</td>
<td>Elaine Goodman</td>
<td>Dawn Tarzia</td>
<td>Overall Score: 2 SD below mean</td>
<td>22</td>
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<tr>
<td>DOM</td>
<td>Palliative Care</td>
<td>OPPE</td>
<td>MD, NP</td>
<td>Lori Smith</td>
<td>Tim Kowalczyk</td>
<td>Overall Score: 2 SD below mean</td>
<td>10</td>
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<td>DOM</td>
<td>Primary Care (Adult)</td>
<td>FPPE</td>
<td>MD</td>
<td>Josh Metlay</td>
<td>Dawn Tarzia</td>
<td>Overall Score: 80%</td>
<td>10</td>
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<td>DOM</td>
<td>Primary Care (Adult)</td>
<td>CRICO Grant</td>
<td>MD</td>
<td>Sandhya Rao</td>
<td>Sue Turner</td>
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<td>DOM</td>
<td>Renal - Nephrology</td>
<td>OPPE</td>
<td>MD, NP</td>
<td>David Steele</td>
<td>Katherine Brock</td>
<td>Completeness: 2 SD Below mean</td>
<td>23</td>
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<tr>
<td>DOM</td>
<td>Urgent Care Unit</td>
<td>OPPE</td>
<td>MD, NP</td>
<td>Brent Ragar</td>
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<td>MD, NP</td>
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<td>Tim Kowalczyk</td>
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<td>Psych</td>
<td>In-patient Psychiatry</td>
<td>Pilot</td>
<td>MD</td>
<td>Janet Wozniak</td>
<td>Elizabeth Porter</td>
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<td>6</td>
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<tr>
<td>Orthopaedics</td>
<td>Podiatry</td>
<td>OPPE/FPPE</td>
<td>MD</td>
<td>Norman Wortzman</td>
<td>n/a</td>
<td>Overall Score: 2 SD below mean</td>
<td>6</td>
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<tr>
<td>Multiple</td>
<td>Credentialing - Advanced Practitioners (NP, PA, CRNA, CNM)</td>
<td>OPPE</td>
<td>NP, PA, CRNA, CNM</td>
<td>Julie Goodman</td>
<td>Julie Goodman</td>
<td>Overall Score: 2 SD below mean</td>
<td>750</td>
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</table>
Outcomes Example: Medical Walk-In

• Initial review suggested medication reconciliation as improvement area

• Average improvement for the department 35% (average from primary review 56%, average from secondary review 91%)
Lessons Learned Outcomes Example: Pediatric Primary Care

Pedi Primary Care Completeness

Rev 2
Rev 1
Lessons Learned: Physician Satisfaction/Engagement

• Physicians are pleased with the process and the ability to earn CME and MOC Part IV credit for conducting quality/process improvements

• 94% of physicians felt there were opportunities to improve clinical documentation

• 67% of physicians felt the on-line tool was easy to use

• 94% of physicians felt the peer-review exercise changed how they document patient encounters
Outcomes: Peer Review used to address medication reconciliation

Participants earn MOC credits through multiple review cycles

Spring 2012: 56%
Fall 2012: 91%
Spring 2013: 95%
Fall 2013: 90%
Spring 2014: 97%
Outcomes: Independent Review of Completeness in Pediatric Primary Care

Blinded review of 120 notes (60 pre/60 post) by 3 pediatricians who did not participate. Each note reviewed by 2 different providers.
**How can MGPO model be implemented elsewhere?**

<table>
<thead>
<tr>
<th>Practice Type:</th>
<th>Hospital-Based Physicians</th>
<th>Non-Hospital Group Practice</th>
<th>Solo Practitioners</th>
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<tr>
<td>Model</td>
<td>• Random or paired peer review by specialty or practice</td>
<td>• Random or paired peer review by specialty or practice</td>
<td>• Would need a community forum for to assign “peer review”</td>
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<tr>
<td></td>
<td>• Align with hospital requirements (OPPE)</td>
<td>• Align with MD requirements (MOC)</td>
<td>• Align with MD requirements (MOC, MOL)</td>
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<td></td>
<td>• Align with MD requirements (MOC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issues to consider</td>
<td>To align with OPPE, need to set performance thresholds</td>
<td>• To align with MOC, feedback and improvement phases are critical</td>
<td>• Would need an institution to manage sharing tools and assignments</td>
</tr>
<tr>
<td></td>
<td>• Aligning peer review with Process Improvement (PI) model does not require online tool</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>or complicated data collection tools</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Does require reporting of results to physicians in a manner that is replicable</td>
<td></td>
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</table>
Challenges

- **Engagement**
  - Docs don't want one more thing to do
  - Meaningful for physicians vs. burden

- **Data**
  - Visit based, not longitudinal
  - Problem specific
  - Authoring of in-patient notes is not clear

- **Methodology**
  - No gold standard
  - Hard to create questions that assess care from just the note
  - Students grading each others papers – valuable but is it the full picture?

- **Feedback**
  - Physicians receive a report on their performance, could do more to facilitate improvement
Thank You

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