

How Much Do Standardized Forms Improve the Documentation of Quality of Care?

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Background. Chart abstraction is a common method for measuring the quality of surgical care. In this study we examine how the use of standardized operative dictation and history forms improves documentation rates of bariatric quality measures.

Materials and methods. Two independent reviewers evaluated 201 patient charts from two multi-surgeon bariatric surgery practices for documentation of five intraoperative and seven preoperative bariatric quality measures. Group 1 used fully standardized templates to dictate or collect both, while Group 2 did not. Documentation rates were compared between the groups.

Results. Operative reports more consistently documented quality assessment information for cases where a dictation template was used *versus* where it was not (89% *versus* 58%, respectively, $P < 0.001$). The greatest discrepancies between the two groups were found in “exploration of the abdomen” (95% in Group 1 *versus* 43% in Group 2, $P < 0.001$) and in “evaluation of the gallbladder” (76% *versus* 28%, $P < 0.001$). In comparison, overall documentation rates for preoperative comorbidities were greater in both groups but remained higher for Group 1, who used fully standardized forms (98% *versus* 74%, $P < 0.001$). Group 1 had statistically significant higher rates of documentation for all seven comorbidities.

Conclusions. The use of standardized dictation templates and history forms is associated with significantly higher documentation rates of quality measures in bariatric surgery. The adoption of these methods into routine use will be needed to allow for

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INTRODUCTION

Recently, an increased amount of attention is being paid to quality of care in surgery. The Center for Medicare and Medicaid Services is considering pay-for-performance (P4P) measures for surgical diseases. Currently, the Center for Medicare and Medicaid Services uses hospital level P4P measures for acute myocardial infarction, heart failure, and pneumonia. Examples of P4P measures for acute myocardial infarction include receipt of a beta-blocker, an aspirin, and an ace-inhibitor [1, 2]. The Hospital Quality Initiative requires all eligible hospitals to submit data on adherence to the quality indicators for these conditions. Hospitals that do not submit performance data will receive a 0.4 percentage point reduction in the annual payment updates [1–5]. Presently, physician-level P4P measures are being considered. Given the current push for these programs, it is important to accurately document adherence to quality indicators.

The reporting of adherence to these quality measures is typically performed by the individual hospital by abstracting the data from medical records. Chart abstraction is one of the most common methods for measuring processes of care [6–8]. The value of chart abstraction as a tool to measure quality in surgery is best illustrated by the Department of Veterans Affairs' National Surgical Quality Improvement Program (VA NSQIP). This program employs 88 full-time, trained surgical clinical nurse reviewers to ensure accurate

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collection of data, which are then transmitted to a national database [9, 10]. Several studies have validated the accuracy and utility of the VA NSQIP collected data [9–14]. The success of this VA program is likely due to (1) a skilled, trained full-time chart abstractor, (2) a computerized medical record with templates for operative notes, progress notes, orders, etc., and (3) on-site auditing of quality of reporting. As evidenced by the success of NSQIP, the use of chart abstraction provides accurate documentation, particularly in a controlled setting such as the VA where trained abstractors are used.

Despite its utility, however, chart abstraction has some drawbacks. First, it is time intensive and costly because it typically requires employment of an on-site nurse dedicated to collecting the data [15], as with VA NSQIP. Second, chart abstraction has primarily been validated only in the inpatient setting [16, 17], and its application in the outpatient setting is not as well-defined [17–19]. Lastly, the usefulness of chart abstraction depends on how clearly and thoroughly the data are documented in the patient's chart [20].

In an effort to improve documentation, there has recently been an increase in the use of standardized dictation templates, history forms, and clinical pathways in many surgical fields [21]. Standardized templates often consist of preprinted forms designed for a specific purpose (e.g., completing a history and physical) so that a provider may save time by checking a box, for instance, rather than writing out sentences. In a recent study by Laflamme *et al.*, operative notes created using an electronic template had faster turnaround times, increased compliance with national standards for operative note documentation, and lower costs [22, 23]. These tools attempt to facilitate correct documentation in a time efficient manner. How the use of standardized templates affects the documentation of quality of care, however, remains unknown.

In this study, we examine how the use of standardized templates affects the documentation of intraoperative quality measures and preoperative comorbidities in bariatric surgery by comparing two different styles of surgical practice. We looked at one group of surgeons employing fully standardized templates for both operative report dictation and patient history (which includes assessment of preoperative comorbidities), and another set of surgeons who do not use a standardized template for operative reports but some partial templates for patient history.

METHODS

A retrospective review of 2 multi-surgeon bariatric surgery practices for documentation of 5 intraoperative quality indicators and 7 preoperative comorbidities. Two independent researchers abstracted information on 201 patients, approximately half from a 4-surgeon private practice bariatric surgery group that utilized standard template operative reports and preoperative patient history forms for

collecting comorbidity data (Group 1, $n = 108$). The remaining half of the charts were from an eight-surgeon academic group (Group 2, $n = 93$) who did not use a standard template operative report or a template for preoperative history to document comorbidities. However, four of the eight surgeons in Group 2 did use a template to obtain a preoperative history. Electronic and paper charts for all patients were reviewed. Cases included both open and laparoscopic Roux-en-Y gastric bypass (RYGB), laparoscopic adjustable bands, and revisions. Patients were selected randomly from each surgeon's practice. In other words, we made an effort to obtain an equal representation of cases for each surgeon.

The operative reports were screened for documentation of five intraoperative quality measures: (1) exploration of the abdomen, (2) examination of the gallbladder, (3) intra- or postoperative evaluation of the anastomosis for leak, (4) closure of the large bowel mesenteric defect or antecolic placement of Roux limb, and (5) closure of the small bowel mesenteric defect.

Group 1 used dictation templates to dictate the portions of the operative report that were similar from patient to patient. Many dictations were performed by the physician's assistant (PA), then reviewed and signed by the surgeon. The PA (four in total) who scrubbed on the case performed the dictation. For cases where the operation deviated from the standard, the dictation was performed by the surgeon, but this occurred rarely. Group 2 did not consistently use a dictation template or a PA to perform the dictations.

The preoperative patient history was examined for documentation of seven comorbidities: (1) diabetes (DM), (2) hypertension (HTN), (3) hyperlipidemia (LIPID), (4) sleep apnea (SA), (5) venous stasis disease (VSD), (6) degenerative joint disease (DJD), and (7) reflux (REFLUX). Preoperative patient histories were taken by several provider types in each practice.

The quality measures selected were previously developed by Maggard *et al.* using evidence in the literature and expert consensus [24]. A summary of the comparison between the groups with regards to the types of data collection forms and degree of standardization is provided in Table 1.

Operative Reports

A standardized abstraction tool that included possible responses of "Yes", "No", "Not reported", "Not applicable" or "Missing" was used. For operative report quality measures, "Yes" was recorded if the operative report confirmed the indicator was met. "No" was assigned if it was clear that the criteria were not met for the particular indicator. "Not reported" was recorded if we were unable to determine if the indicator was met or not. For example, if the surgeon did not comment on whether an anastomotic leak test was done, then "Not reported" was assigned. For the analysis, "Yes" and "No" were classified together, because the record contained data to determine whether the indicator was met or not, thus satisfying that the data were documented. In contrast, "Not reported" meant that the data were not sufficiently documented in the records. "Not applicable" was assigned if the patient was not eligible for the particular indicator; for example for a patient who had previously undergone cholecystectomy, the indicator specific to the gallbladder would not be eligible. For the purpose of our analysis, an assignment of "Yes" was required to satisfy the criterion that the operative indicator was documented. "Missing" was assigned when the operative report was not found in the medical record, either the paper chart or electronic records.

Preoperative Comorbidities

For assessing the preoperative comorbidities, we reviewed all history forms and patient intake forms. "Yes" was recorded if there was documentation that the patient suffered from the comorbidity, and "No" was recorded if there was documentation that the patient did not have the comorbidity. For example, the history or patient intake form must document "no diabetes" to get credit for assign-

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