Alerts to Improve Chart Documentation for National Quality Measures

Kevin M. Heard, BS¹, James M. Hollands, PharmD, BCPS¹, Laura A. Noirot, BS², Richard M. Reichley, RPh¹, Thomas C. Bailey, MD¹²
BJC HealthCare¹ and Washington University School of Medicine², St. Louis, MO

Abstract
Clinical decision support (CDS) rules monitoring adherence to guidelines for secondary prevention of acute myocardial infarction (AMI) have been in use at BJC HealthCare’s academic facility for five years. The alert web response form for these rules was enhanced to facilitate documentation of contraindications for ACE/ARB, beta blocker, aspirin, and lipid-lowering medications. An analysis of the impact of these enhancements and the changes to pharmacy workflow are presented here.

Introduction
Pharmacists received CDS alerts for AMI patients not prescribed one or more of the medications recommended by ACC/AHA guidelines and measured as part of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) ORYX® core measures¹. The pharmacists assessed each patient’s eligibility for the guideline and intervened with the physician when appropriate. Results of the intervention were recorded on the alert form. Although clinical contraindications were recorded by pharmacists on the form, some cases were considered nonadherent when assessed by chart abstractors using JCAHO definitions of adequate documentation.

Methods
Prior to May 2006, pharmacists reviewed charts for each alert to identify clinical contraindications for the medications and recorded these on the alert form without contacting the physician. When no contraindications were found, pharmacists contacted the physician to prescribe the indicated medication. Beginning May 2006, alert forms were modified to allow pharmacists to track the status of physician documentation of medication contraindications. A printable chart form served as a documentation tool. The printable form included pre-printed demographic information and checkboxes for common contraindications for the drug classes not prescribed.

The pharmacist workflow was modified to identify adequate documentation as defined by JCAHO requirements. If found lacking, the pharmacist placed the chart note to educate physicians about the AMI guidelines as well as to facilitate prescribing the medication or providing adequate documentation.

The alert remained active until there was adequate documentation in the patient’s chart.

Results
For purposes of illustration we show ACEI/ARB results here. Chart 1 contains ACEI/ARB adherence data for AMI cases from 2006 that were eligible per both JCAHO and pharmacist assessment. Although there was no apparent change in the percent of adequate contraindications identified by chart abstraction after the enhancement in May, pharmacists consistently reported the same or more contraindications and fewer nonadherent cases when compared to chart abstraction.

Chart 1. ACE/ARB Assessments for 2006

Conclusion
Although pharmacists continue to identify clinical contraindications, the alert enhancement has not been reflected in the JCAHO measures. This indicates at least two potential problems with this intervention which point to poor documentation rather than poor quality of care: 1) Abstractors are not reliably finding chart documentation, 2) Pharmacists and physicians need further education regarding the JCAHO definition of adequate documentation and should not just focus on clinical contraindications. Both of these issues are being addressed and additional data is being collected in order to enhance the effectiveness of this intervention.

References