In the rapidly evolving world that is health care, the electronic health record (EHR) is changing the way healthcare documentation is created and used. Government regulations and incentives have spurred rapid acceleration in deployment of the EHR in healthcare facilities. The push for shortened hospital stays has required improved availability of documentation to clinicians, who need reports in real time for decision-making in care and treatment of the patient. Additionally, patients now have online access to their healthcare records; the healthcare record and its accuracy have a direct impact on patient satisfaction. Therefore, quality and accuracy of documentation is now more important than ever.

Clinician-created documentation comprises a greater percentage of the healthcare record than in the past, yet traditional transcription still holds an important role as a documentation practice that many clinicians are unwilling to relinquish. Both front-end and back-end speech recognition are widely used, yet careful review and editing by the healthcare documentation specialist (HDS) and by the clinician continue to be required to achieve optimal results. As new trends and roles become more firmly established, the need for a unified set of standards in quality assessment, one that is applicable for both HDS-created and clinician-created documentation, has become pronounced, both from the perspective of the equivalency of errors being made and for ease of use by the quality assurance workforce. It is for this reason that the AHDI quality assurance best practices of 2010-2011 and the clinician-created documentation quality assurance program of 2014 have been combined in this new toolkit of best practices for all.

What is quality, exactly? Quality of healthcare documentation includes several elements, the first of which is accuracy. Accuracy of data is required in both form and content. The determination of accuracy requires specifications and criteria against which to measure. Context is critical, and the data must satisfy the requirements of its intended use. To satisfy the intended use, the report must be accurate, timely, relevant, complete, understandable, and authentic or trustworthy. ("Authenticity of documentation," simply put, means that the data is what it purports to be.) These criteria are addressed in the combined and updated *Healthcare Documentation Quality Assessment and Management Best Practices* (QA Best Practices) to:

- Help ensure quality and consistency of records for various purposes to include automated decision support, research, and core measure outcomes.
- Increase awareness of patient safety, focus on critical errors impacting patient care, and emphasize the need to manage critical errors.
- Combine the two programs to standardize quality processes and goals.

- Bolster coding, billing, and reimbursement, which increasingly requires accurate and consistent documentation.
- Support healthcare documentation as a definitive evidential resource to defend against malpractice or fraudulent billing claims.
- Assist organizations that have not yet implemented clinician-created documentation quality assurance programs and offer samples and suggestions for implementation.
- Support traditional QA staff as they transition into evolving roles such as clinician-created documentation auditors.
- Assist facilities and businesses in updating their existing QA program, or starting one, for traditional transcription and/or speech recognition editing.

This toolkit:
- Establishes standards applicable to all methods of document creation, including traditional transcription, back-end and front-end speech recognition, and clinician-created documentation.
- Assists in the creation of quality audits that are objective and measurable.
- Establishes streamlined and clearly-defined error categories for clear understanding and ease of use.
- Supports transparency in the quality assurance (QA) process.
- Raises the level of quality awareness within a healthcare organization and throughout the clinical documentation profession.
- Recommends consistent review and scoring of quality audits.
- Allows for constructive, unbiased, and actionable feedback to be given to healthcare documentation specialists as well as clinicians and their scribes.
- Offers tools for both tracking of data and process improvement, leading to improved decision-making.
- Further emphasizes the importance of, and leads to, improved patient safety, care, and outcomes.
- Promotes and supports the implementation of updated standards.
- Provides practical tools for implementation.
- Offers tools for presentation to clinician and HDS staff, management, and administrators.
- Provides suggestions for transition and implementation of updated QA Best Practices for both HDS-created and clinician-created documentation.

The updated QA Best Practices toolkit draws on the knowledge and experience of numerous and varied healthcare organizations and businesses that routinely assess the quality of documentation produced by their HDS and clinician staff, as they endeavor to educate and continuously improve the quality and accuracy of the health record for patient safety, care, and improved outcomes.