At the Crossroads:
Clinical Documentation & the EHR

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PATIENTS

PAPERWORK

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Executive Summary

As healthcare reform transitions from volume-based reimbursement to value-based reimbursement, physicians and healthcare organizations must justify patient treatments and demonstrate quality outcomes. The key to accomplishing these objectives is through complete and accurate clinical documentation.

Confronting the mission to produce the highest data quality possible is a core challenge in clinical documentation. We clearly need structured, codified, and normalized data that can be accessed and analyzed. At the same time, there remains a strong demand for the context, detail, and reasoning that unstructured narrative documentation uniquely generates.

The core strategy for improving clinical documentation is by embracing the reality that different styles of documentation are best suited to different types of patient information. Some data is quickly and accurately captured in forms, fields, and templates – such as data entered via EHR templates. Whereas, some information is only viable through narrative patient analysis.

A blended, hybrid approach to clinical documentation delivers many advantages, including:

- Returning time back to caregivers. Time is a physician's most valued commodity and more of it means more time for patients and clinical work.

- Preserving the narrative context and detail that is absolutely vital to data quality and the analytics that rely on such data.

- Making the EHR documentation experience far better for all healthcare professionals.

Framing the Issues

The shift from volume-based reimbursement to value-based is a clear and well-documented imperative. Yet the industry mission to balance the cost/quality equation involves a complex array of mandates and initiatives, nicely summarized in a recent article by a consulting group (and in Figure 1): "Success in this new business terrain means health systems utilizing Value-Based Care models must reimagine how to collectively engage patients, providers, and practices to increase collaboration and participation across the continuum of care; use technology to improve the quality of and access to care; aggregate data from health plans, clinical systems, and practice management systems; and use analytics to provide actionable intelligence prospectively and at the point of care." [1] Clearly this is a tall order for healthcare organizations!
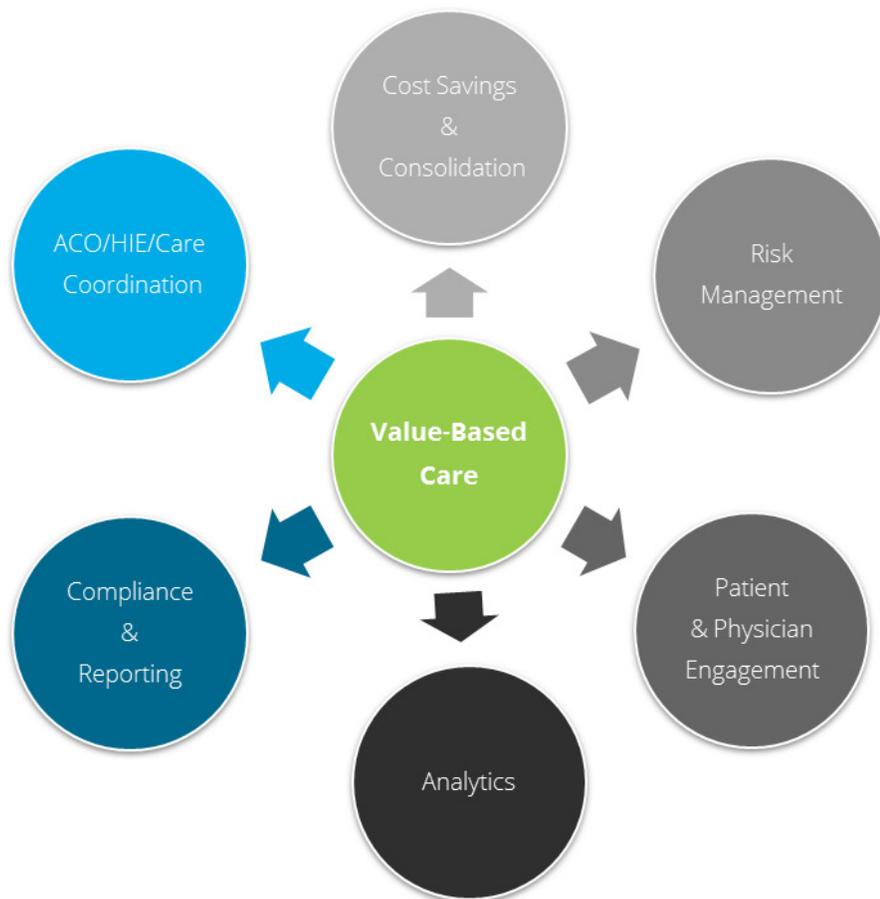

Figure 1

Effective management of these diverse strategies rests on an essential requirements chain as shown in Figure 2. Briefly, the migration from volume to value encompasses broad population health management and care coordination driven by analytics. Meaningful, quality data is absolutely fundamental to successful analytics, both retrospective and predictive. Such data, of course, originates heavily from clinical documentation.
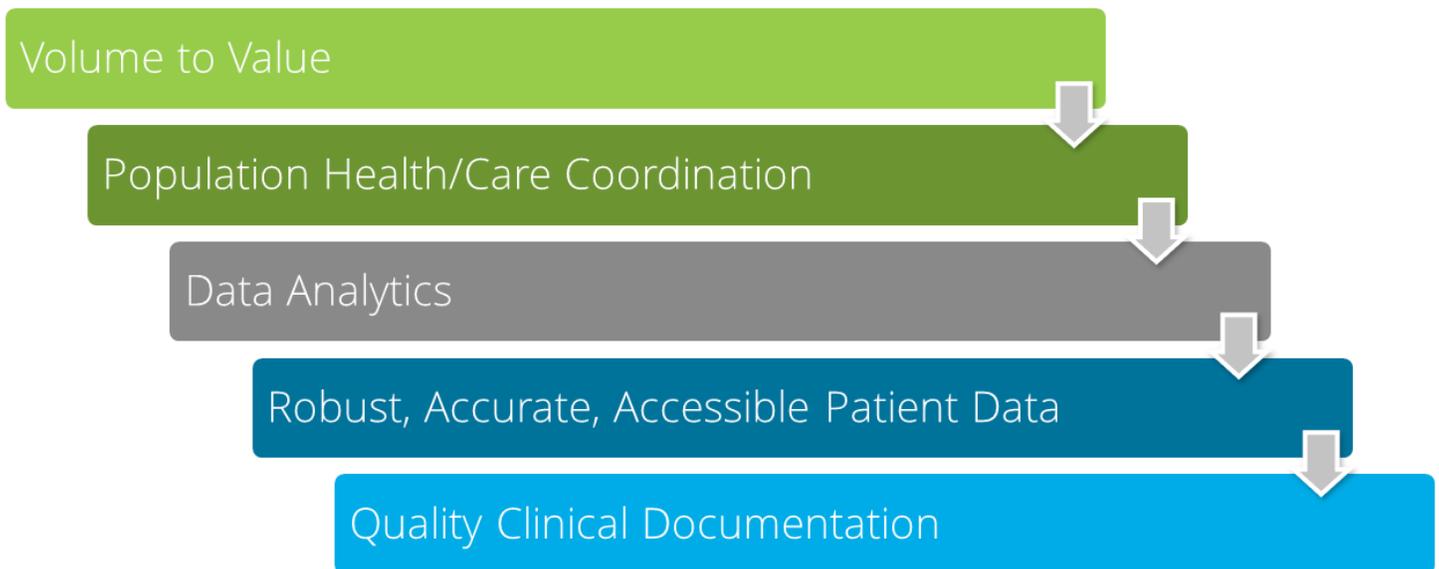
| Volume to Value |
| Population Health/Care Coordination |
| Data Analytics |
| Robust, Accurate, Accessible Patient Data |
| Quality Clinical Documentation |

Figure 2

The Clinical Documentation Challenge

Given the foundational role of clinical documentation, considerable attention is being devoted to analyzing its current effectiveness. The starting point for this assessment is the growing realization that data quality matters. Noting that "data quality is a huge issue," Judy Hanover of IDC Health Insights explains that data analysts are struggling to "understand the origins and elements that are contained in that data…and put it together in a way that yields meaningful results." [2]   Furthermore, a leading executive with Premier Inc. describes the results of a recent survey: "We just interviewed… executives down to analysts, and the No. 1 issue they mentioned by far is data quality." [3]

Confronting the mission to produce the highest data quality possible is a core challenge in clinical documentation. We clearly need structured, codified, normalized data that can be accessed and analyzed. At the same time, there remains a strong demand for the context, detail, and reasoning that unstructured narrative documentation uniquely generates.

Many believe that capturing the full context of a patient encounter – the complete patient story – is essential to arriving at meaningful data. Context and detail help resolve accuracy and other data problems. Contextual information has acquired greater significance in a healthcare system that places a premium on collaboration. As caregivers coordinate across sites, they need the total patient picture, not simply a collection of data points and template output. In addition, "big data" engines such as IBM Watson seek as much information as possible, including mining unstructured clinical notes in collaboration with M.D. Anderson to help derive cancer treatment recommendations. IDC's Hanover adds that "the value in unstructured data is clearly there for organizations." [5]

Dictated narrative has long been the gold standard for capturing such context, which is highly valued by physicians. As one study of clinical judgment puts it:

"Despite all the prohibitions against 'anecdotal knowledge' in medicine, case narration is the principal means of thinking and remembering – of knowing – in medicine. The interpretive reasoning required to understand symptoms and signs and to reach a diagnosis is represented in all its situated and circumstantial uncertainty in narrative." [6]

The industry solution to the quest for quality patient information has been a massive investment in electronic health record systems accompanied by a dedicated effort to implement them in virtually all healthcare organizations. EHRs have become the primary tool for documentation.

EHR Dissatisfaction on the Rise

Having attained wide adoption, the focus has turned to realizing the promise of EHRs and delivering the benefits of this technology, a more difficult task. As the healthcare industry evaluates its progress, they are finding growing dissatisfaction both at the institution level and the physician level. Several recent survey findings are indicative:

- "Up to one third of hospitals are dissatisfied with their EMR or electronic health record (EHR) system." [7] Two key reasons expressed: a) cumbersome and complex interface and b) poor usability.

- 41% of hospital C-suite executives polled report being "dissatisfied" with or "indifferent" about their existing EHRs, with "cost and difficulty of use" being primary issues. [8]

- "One in six medical practices report plans to change their existing EMR because it is not meeting the needs of the practice." [9]

"...one third of hospitals are dissatisfied with their EMR or electronic health record (EHR) system."

- 20% of community hospitals were actively seeking EMR replacement, with "usability and inadequate functionality" as the biggest challenges cited. [10]

This dissatisfaction extends to documentation. Today's EHR systems excel at many functions, but still have a number of significant limitations when it comes to documentation. The template-driven, point-and-click EHR paradigm creates several problems:

- It slows down physicians. In the Black Book Review survey, 88% of users considering EHR replacement reported productivity declines. A recent Deloitte survey revealed that 3 of 4 physicians feel EHRs "do not save time".[11]

- Standardized content contained in templates is sometimes inappropriate for specific patients, which can create confusion and lead to poor care decisions. The absence of ongoing human QA review of this documentation, as was available via transcription, exacerbates the problem.

3 of 4 physicians feel EHRs "do not save time".

- Copy-paste practices that "can cause documentation that is redundant, erroneous, or incomprehensible and contribute to billing fraud," according to the American Health Information Management Association.

- It does not fit the "cognitive" workflow of caregivers. Templates are often impossible to design in ways that conveniently capture the rationale for physician judgments, or the progression of observations and conclusions over time. These details and thought processes are prized by physicians, as this recent conclusion attests: "A medical record – whether paper or digital – must preserve the information that the physician carefully and thoughtfully elicits from the patient in a form that, above all, facilitates clinical reasoning. Current EHRs do not." [12]

At the same time, more and more hospitals and groups are debating the cost tradeoffs of physician data entry and EHR documentation. As Figure 3 displays, we have placed the burden on the costliest agent – the doctor – who is also the least specialized and focused on the process. Physicians know documentation is vital, but most of them view the task as practicing far beneath the "top of their licenses." Shifting the effort to nurses or scribes is also costly. And with doctors and nurses, valuable time is taken away from critical patient care work with corresponding patient satisfaction implications.

The classic model of physician dictation completed by a skilled speech editor remains highly cost-effective and an optimal skill set match.
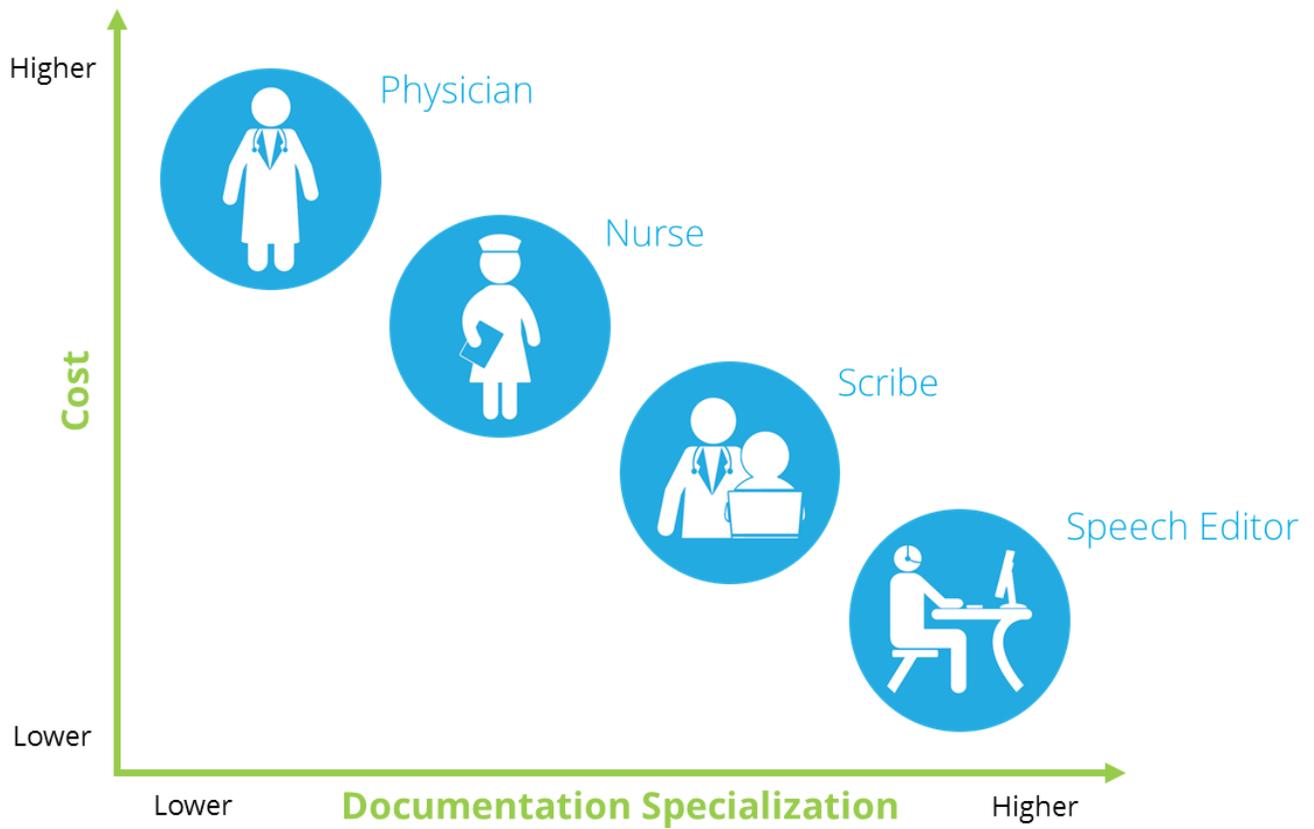
Figure 3

EHR at a Crossroads

The EHR has arrived at a critical juncture. The urgency to achieve the promise of these systems is requiring organizations to address the fundamental documentation challenge and overcome the realized issues slowing full EHR adoption – such as physician dissatisfaction, loss of productivity, increased time investment in documentation, poor usability, and increased risk. What is the best path to generate structured discrete data while preserving context and clinical reasoning ideally captured through narrative?
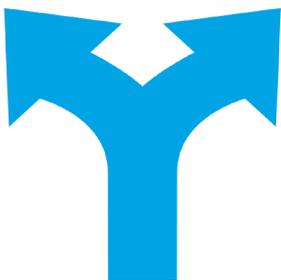
One-size-fits-all documentation is not the answer.

Resolving the dilemma means managing a hybrid world in which a range of styles is not just tolerated, but also supported and optimized to create a rich, agile, and effective documentation environment. It is an environment that respects diverse workflows and fosters physician engagement, a critical goal in healthcare organizations.

Strategies & Best Practices

The core strategy must begin by embracing the reality that different styles of documentation are best suited to different types of patient information. Some data is quickly and accurately captured in forms, fields, and templates; other information is only viable through narrative. The ideal system would automatically default to the best style/information match. Providing choice is thus not merely about user preference; it relates to more fundamental data realities.

Additional strategic best practices include:

- Supporting flexibility for each author to use direct data entry, speech recognition to fill in forms and invoke templates, speech recognition for free text, and straight dictation/transcription. All methods should be integrated or interfaced with the EHR. Further choice that encourages usage involves offering both real-time speech recognition with physician self-edit and background speech where an editor completes the report. All options can be managed centrally with single profiles and streamlined workflow algorithms.

- Extending flexibility to mobile devices. Today's speech recognition systems provide robust functionality on smartphones and tablets, a significant benefit for physicians, particularly in outpatient settings.

> *Embrace the reality that different styles of documentation are best suited to different types of patient information*

- Creating a strong blend of technology and human expertise. Healthcare has certainly learned by experience that automation is not a panacea, despite claims for various technologies. When skilled individuals backstop advanced technology, optimal outcomes frequently result. Given the need for data optimization, enabling a human Quality Assurance component in the workflow is critical. Transcriptionist-assisted speech recognition is one strong way to permit review of documentation for omissions, inconsistencies, and other errors.

Advantages

Executing the direction outlined above creates many advantages and benefits that justify the investment. Among the most significant:

- Returning time back to caregivers. Time is a physician's most valued commodity and more of it means more time for patients and clinical work.

- Preserving the narrative context and detail that is absolutely vital to data quality and the analytics that rely on such data.

- Making the EHR documentation experience far better for all users, boosting physician adoption and satisfaction.

- Generating compelling cost savings.

Objections & Key Considerations

Supporting narrative documentation alongside electronic health records is not without legitimate concerns, and it is important to address them in developing a comprehensive approach. Several key objections are frequently raised.

First, some suggest that the hybrid documentation model conflicts with overall EHR strategy. However, flexible documentation offerings do not imply a reduced commitment to the EHR. Implemented correctly, the hybrid strategy enhances and enriches the EHR. Integration of speech recognition allows voice-driven templates, additions of text "snippets" to a template, or full text narrative to adapt to different patient stories.

Second, some organizations have turned to "medical scribes" to overcome some of the EHR deficiencies. This solution is costly and difficult to scale. It also does not help with the more fundamental issue: the need to capture clinical reasoning and context.

Another broader concern is lack of bandwidth for another IT project. Certainly healthcare IT departments have a full menu of initiatives and limited staffs to complete them. The good news here is that today's speech-based systems can operate effectively in the cloud and do not involve extensive implementation. Advances in the technology also permit user voice profiling in unobtrusive ways and a rapid ramp to user productivity.

Conclusion

The journey to value-based care is complex and dependent on the highest quality information. Clinical documentation plays a crucial role on this journey. Why limit the tools available to us to generate rich, complete, physician-valued, and patient-friendly information? Promoting choice promotes narrative context, bringing the desired destination into view more quickly.

Author

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