

Abstract

A well-documented medical record is essential to providing quality care and should tell a complete patient story. It should be documented expeditiously, but thoroughly, to enable physicians and other healthcare professionals to make timely decisions based on all available patient information.

In the age of the electronic health record (EHR), point and click medical record templates have improved the capture of structured data, but increased documentation demands and not-so-friendly user interfaces are burdening physicians. Physicians are spending more time entering data and working longer hours, while less time is spent interacting directly with patients. In addition, poor clinical documentation practices still exist, including:

- Gaps or delays in documentation
- Data entry errors from manually typing or copying and pasting from other records
- The loss of narrative documentation and detailed notes
- Records missing documents or entries, which can compromise patient safety

Physicians need tools that help them focus on patient care, not on paperwork.

The latest advancements in speech-enabled documentation enable physicians to focus on patient care and maintain quality of life, while helping to meet documentation requirements and assisting in accurately telling a patient's story. This paper discusses some of the top benefits narrative dictation and speech-enabled documentation provide in an EHR environment.

Introduction:

EHR Adoption & Narrative Dictation

In 2009, the U.S. federal government enacted the Health Information Technology for Economic and Clinical Health (HITECH) Act. Under the HITECH Act, the U.S. Department of Health and Human Services (HHS) was authorized to establish programs to promote the adoption of health information technology, especially the use of EHRs. To boost adoption, Medicare and Medicaid incentive payments were established.

In order to secure the incentives and avoid penalties under this program, hospitals and providers must adopt EHRs certified for health information technology to support 'Meaningful Use' (MU), as defined by the Centers for Medicare & Medicaid Services (CMS). MU constitutes achieving specific CMS-determined objectives that revolve around three stages, as follows:

- Stage 1: Adopting EHRs and data gathering
- Stage 2: Advancing care coordination and the exchange of patient information
- Stage 3: Improving healthcare outcomes

One of the key aspects for attesting to MU, and improving data gathering and sharing, is through the promotion of structured data that can be analyzed and shared easily. While the importance and benefits of data sharing is recognized by providers, it has come at a cost.

The increased need for structured electronic data landed directly on physicians in the form of increased clinical documentation requirements and time spent on point and click data entry into EHR templates. Prior to this, a majority of healthcare documentation was paper-based and created with the help of dictation and transcription.

As of April 2015, 98 percent of all hospitals and 95 percent of Critical Access and small rural hospitals have demonstrated MU and/or adopted, implemented, or upgraded an EHR.¹ But while adoption is at an all-time high, satisfaction has plummeted. According to data collected by AmericanEHR and presented at HIMSS13, around 40 percent of physicians would not recommend their EHR to a colleague.² Furthermore, a survey published in JAMA online found that 89.8 percent reported that at least one data management function was slower post-EMR adoption, and 63.9 percent reported that note writing took longer.³

To address some of the issues surrounding EHR data entry and documentation, many providers are discovering that dictation and narrative transcription are still necessary for proper patient care. The narrative continues to be essential for creating an optimized and accurate description of patient encounters, and when blended or integrated with an EHR, speech-enabled documentation capabilities and transcribed reports actually increases productivity as well as document quality.

Benefits of Narrative Dictation in an EHR Environment

Below are the top 7 benefits narrative dictation and speech-enabled documentation provide in an EHR environment.

1 Saves Time & Increases Physician Productivity

For physicians every minute counts and reduced physician productivity is increasingly becoming documented as an unintended consequence of template-based EHR documentation.

As reported by Luc P. Beaudoin on the CogZest™ blog, through the use of a traditional keyboard, most people only type 20-30 words per minutes, and touch-screen typing is worse. Professional typists, on the other hand, type around 57 net words per minute. However, lecture speech is about 142 words per minute. These findings suggest the significant potential productivity benefits for dictation.⁴

Considering that physicians are very busy and that they are the primary revenue earners in a hospital, having physicians' click through and type patient notes into an EHR system is a waste of their valuable time. It lowers productivity leading them to see fewer patients per day. Speech-enabled documentation allows providers to use their voices to thoroughly document patient encounters, as dictating is faster than pointing, clicking and typing notes. This allows physicians to save time and improve their productivity.

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2 Reduces Data Entry & Documentation Costs

Physicians' time is better spent on patient care than as a resource for data entry tasks. By pairing narrative dictation with speech recognition, intelligent workflow management software, and/or in-house or outsourced transcription, hospitals can reduce their overall operating costs. Hospitals typically find that their reports are done faster and with fewer errors when they use skilled clinical documentation specialists and editors.

Dictation is the most efficient way to document patient care, as reported by Robin Daigh. "Take the example of a typical outpatient visit to an internist. It takes about one minute to dictate a note for an established patient and about \$4.30 in direct and indirect costs. By contrast, many EMRs

use structured data entry as the primary method for entering clinical notes, in which physicians point and click their way through dropdown menus. The time required is at best equal to that of a transcribed note, and physicians often report it takes 8 to 10 minutes to complete a note using structured data entry, meaning that the indirect cost to physicians is anywhere from \$13.50 to \$27.00.”⁵

Time-intensive EHR documentation can also lead to physicians seeing fewer patients in a day, which ultimately equals decreased revenue. By using speech-enabled clinical documentation, physicians can see more patients each day, keeping revenues up.

Clinical narratives also drive coding and billing. To ensure maximum reimbursement, physicians must accurately and comprehensively document the services they provide, but template-based methods can limit a physician’s ability to do just that. To ensure appropriate reimbursement, ICD-10 calls for the highly specific and thoroughly recorded patient information contained in the narrative.

3 Integrates with & Enhances EHR Documentation

Advancements in speech-enabled clinical documentation technology allow for dictated, narrative-based documentation to be integrated back into one or more EHR system or other Health Information Systems (HIS). This enables physicians to generate documentation faster and in a more natural manner, using a method that many physicians learned in college — dictation.

With recent innovations in voice recognition technology, physicians can even dictate data directly into an EHR platform, also improving clinical documentation speed and the completeness of patient encounters. In fact, 9 out of 10 hospitals plan to expand their use of front-end speech recognition, according to a KLAS report (as reported by Clinical Innovation + Technology).⁶

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In-house or outsourced medical transcription support staff can transcribe the dictated reports, then put the content into the proper EMR text fields using discrete reportable transcription (DRT) or by using an integrated dictation, speech recognition or clinical documentation system integration via HL7. By integrating narrative document production with EHRs, providers can still meet MU requirements, while being able to efficiently record complete and accurate patient information.

4 Enhances EHR Documentation & Creates Meaningful Notes

Narrative documentation enables physicians to dictate thorough, data-rich patient information. Capturing the full context of a patient encounter — the complete patient story — is essential to

arriving at meaningful results that also improve value-based healthcare initiatives. Context and detail can also help resolve accuracy and other data problems.

As providers coordinate across sites, they need the total patient picture, not simply a collection of data points and template output. Narrative-based clinical notes are proving to be valuable for clinical documentation, as well as healthcare data analytics. For example, in a recent study, IBM's Watson mined unstructured clinical notes in collaboration with M.D. Anderson to help derive cancer treatment recommendations.⁷ Movable narrative reports, whether speech-generated or dictated and transcribed, can optimize medical billing and allow for the structured details to be reported.

Capturing patient information via narrative dictation can clarify patient records and lead to more comprehensive medical charts that can easily be used by medical billing personnel, clinical documentation specialists, or other clinicians along the patient's journey.

5 Improves Patient Care & Safety

In the process of digitizing patient information and with the increased usage of EHRs, it had been assumed that patient medical records would be more complete, created faster, and provide substantial cost savings to hospitals, while improving the quality of care and patient outcomes. However, studies have shown that in some cases, the adoption of highly-structured EHR templates are not efficient and do not lead to higher quality care. According to The Physicians Foundation's *2014 Survey of America's Physicians: Practice Patterns and Perspectives*, "85 percent of physicians surveyed indicate that they have implemented electronic medical records (EMR). Yet, only 24 percent say that EMR systems have improved efficiency and only 32 percent indicate that it has improved quality of care. Nearly half of respondents (47 percent) noted that EMR systems detract from patient interaction."⁸

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Patients, too, are seeing the effects of physicians spending too much time in front of a computer screen. Suneel Dhand, MD stated: "Talk to many patients who interact with their physicians — especially in office settings — and they will cite their personal annoyance with the fact their doctor hardly looks them in the eye anymore. 'Every few seconds the doctor just kept turning around and looking at their screen and typing away,' is a common complaint."⁹

Dr. Dhand also reported that "studies suggest that newly graduating physicians are spending an absolute minimum amount of time every day in direct patient care (as little as 10 percent)...As I look around at lots of my hospital medicine colleagues, they are easily spending over 75 to 80 percent of their day staring at screens."⁹ Very concerning statistics indeed!

As well as the reduced doctor-patient interactions, copying and pasting within EHRs has become a normal but dangerous process, as physicians seek ways to complete EHR documentation faster. Not only can this process lead to risk and patient safety-related issues, copy-and-paste practices can also cause documentation that is redundant, erroneous, or incomprehensible, which can contribute to billing fraud, according to the American Health Information Management Association (AHIMA).¹⁰

Narrative-based dictation and speech-enabled documentation can help. Narrative documentation aids in providing a faster and more accurate way for physicians to document patient encounters quickly and thoroughly, so they can focus on the patient and not be hidden behind a monitor. In addition, by documenting in a narrative-based manner and through the use of speech recognition templates, physicians can quickly document information, without feeling the urge to copy and paste in order to work faster.

Still, no matter who is documenting patient information, the devil is in the detail, which needs to be rich with patient data — in order to produce better care and appropriate reimbursement. Clinical narratives include more complete patient stories. Dictation and speech-enabled documentation provide a better method to accurately describe specific clinical events or situations, which leads to improved patient safety and reduce clinical risk.

6 Reduces Insurance Denials & Malpractice Risk

Insurance companies are looking for more reasons to deny coverage today than ever before, which means providers must diligently specify why they recommended treatments or procedures.

The medical necessity documentation delineates the medical pathways. Physicians of all practices, including surgeons, are now being asked to document those pathways to clarify medical necessity. Clear documentation of medical necessity helps with coverage for treatments and procedures. In addition, it supports a provider's decision in the event of an audit.

As noted on Becker's Spine Review, "It used to be that surgeons could just see their patients, do the physical and choose the treatment pathway," says Marcy Rogers, president and CEO of SpineMark, a developer of spine centers of excellence and spine research organizations. "Now they need to start thinking about what supports medical efficacy and acuity of the treatment."¹¹

In addition to insurance purposes, medical records are also legal documents, and how a physician documents in the medical record is critically important in defending a possible malpractice lawsuit. Juries place great weight on what information is and is not in the medical record and when that information was entered. Detailed documentation can either disprove or bolster disputed testimony between a physician and a patient, regarding what and when something happened. Good charting practices and detailed documentation help to reduce the risk.

Narrative-based documentation makes it easier for physicians to thoroughly record patient stories, while helping to ensure that complete and accurate clinical documentation is available for insurance reviews, audits, and medicolegal purposes.

7 Hybrid Documentation Gives Physicians Choice

Both types of data — structured and unstructured — are important to proper clinical documentation and for achieving MU. However, the constant tug-of-war between practical use and meaningful use of EHRs for documentation leads to slower adoption, increased dissatisfaction and the reduced chance of organizational success. This reality has led to a more practical approach to clinical documentation, where dictation and transcription works side-by-side to accelerate the use of EHRs.

The blended or hybridized approach to clinical documentation enables different methods for capturing and/or entering data — such as typing, standard dictation and transcription, or by means of speech recognition. With this approach, physicians can utilize their preferred method or methods for document production. For example, structured history information, drug lists, and physical templates populated by a nurse or physician assistant may be used in one care setting, while a dictated and transcribed narrative report may be the best documentation method for inpatient discharge summaries, notes, and assessments.

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Speech recognition options can also be used to give physicians the best of all worlds and further enhance templated documentation. Eve-Ellen Mandler, RHIA, MS, CCS, FAHIMA, is director of HIM and privacy at St. Clair Hospital in Pittsburgh, PA. According to an article published through AHIMA, she stated that, “physicians get the information they want and need into the reports without changing their practice patterns while HIM reduces cost and improves efficiency.”¹²

Furthermore and described as a “Framework for Success” for template-dictation documentation environments, Marilyn Trapani discusses another blended approach in an article published in *For The Record* magazine. “Designed by medical records committees and approved by physician leaders, templates for report types can be created to meet ICD-10 requirements. Trained physicians dictate the necessary information, and a transcriptionist enters the data into a concise file format. If an organization opts for partial dictation, the report’s transcribed section can be uploaded via a Health Level Seven International format to the chosen EMR and melded to the check-box information that the physician selected to begin the process.”¹³

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

- Returning time back to clinicians
- Preserving the narrative context and detail
- Making the EHR documentation experience and usability better

Instead of forcing physicians to change, hospitals should work with them and offer flexible, integrated solutions such as speech recognition, dictation, and transcription. The hybrid approach to clinical documentation better supports physician workflow and helps to streamline documentation — so it is not interrupted, achieves better clinical outcomes, and improves patient and physician satisfaction.

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