REMOVING THE NONSENSE, RESTORING THE STORY

Clinical Documentation in the EHR Era

Elsa L Vazquez Melendez, MD, FAAP, FACP
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Disclosure

- No conflict of interest.
Objectives

- Describe the current state – Categorize types of deficiencies
- Identify drivers of poor documentation
- Describe the rationale for better notes
- Present best practices – The 10 Commandments
History of Electronic Health Records

- The development of an IT infrastructure has enormous potential to improve the safety, quality, and efficiency of health care in the United States. (Institute of Medicine, 2001)
Key Capabilities of an Electronic Health Record System

- Promote safety, quality and efficiency in health care delivery
- Core functions for EHR systems
  1. Health information and data
  2. Result management
  3. Order management
  4. Decision support
  5. Electronic communication and connectivity
  6. Patient support
  7. Administrative processes and reporting
  8. Population health
Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009

- Part of the American Recovery and Reinvestment Act (ARRA)
- Signed into law by President Obama with an explicit purpose of incentivizing providers (e.g. hospitals and physicians) to adopt EHR systems
- HITECH Act requires that providers adopt EHRs and utilize them in a “meaningful” way, which includes using certain EHR functionalities associated with error reduction and cost containment
Percentage of office-based physicians with EHR systems: United States, 2001–2013

CDC/NCHS, National Ambulatory Medical Care Survey and National Ambulatory Medical Care Survey, Electronic Health Records Survey.
### Certified Health IT Vendors and Editions Reported by Hospitals Participating in the Medicare EHR Incentive Program, July 2016

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<th>Vendor</th>
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Percentage of electronic health record system adoption, by physician age, practice size, ownership, and specialty, 2011

CDC/NCHS, Physician Workflow study, 2011
Percentage of physicians whose electronic health records provided selected benefits: United States, 2011

- Accessed patient chart remotely: 74%
- Alerted to critical lab value: 52%
- Alerted to potential medication error: 43%
- Reminded to provide preventive care: 40%
- Reminded to provide care meeting clinical guidelines: 38%
- Identified needed lab tests: 29%
- Facilitated direct communication with patient: 25%

**Patient-related outcomes**
- Enhanced overall patient care: 74%
- Ordered more on-formulary medications: 44%
- Ordered fewer tests due to lab results’ availability: 30%

CDC/NCHS, Physician Workflow study, 2011
What would you consider should be at the forefront of the electronic health record era?

*Documentation Integrity*
Airway open and patent. Breathing is spontaneous. Pulses are present.

Patient is awake and alert. Affect, orients appropriate, and speech are age-appropriate.

Arrival: Patient arrived by stretcher via ENS transport from home accompanied by T/paramedic <KCT 18:08>

Patient has not traveled outside the triage system <KCT> Ready for complete trauma assessment <KCT 18:10>

ESI level 3 <KCT 18:10>

Patient's language is: English. Information received from patient not applicable. Private physician: <KCT 18:10>

Fall Risk Assessment Form <KCT 0 18:10>

Patient is placed in the treatment area and determined a high risk for falls. Stretcher in low position, wheels locked, and when cares are not being performed, both side rails are to remain up. Call light is within reach of patient/caregiver. Patient/caregiver instructed on fall precautions and up. They are encouraged to call for assistance.

Pt/parent expresses no concerns for safety in current relationships. <KCT 18:11>

Current completed, <18:26> Allergies

I mg Monthly

Run: by
Primary Goals of Documentation

- Inclusion of a descriptive narrative of the particular patient and the relevant points of their presentation, medical history and social context
- Impression, differential diagnosis and plan for the future reference by the physician, benefit of consultants, and use by other caregivers
The EHR Era

“The doctor will be in shortly to type on the computer and update your chart. If he has time, he will ask how you’re feeling and take a look at your rash.”
Deficient Notes - Categories

1. Information Overload
2. Loss of the Story
3. Inaccurate Documentation
4. Deceptive Documentation
Categories of Deficient Notes

1. Information Overload

- Mandatory templates
- Laboratory and radiologic studies
- Compendium from prior notes
- Medication lists
- Importation of irrelevant data
Categories of Deficient Notes

2. Loss of the Story

- Poor History
- Minimizing Clinical Reasoning
- Lack of humanistic elements of physician-patient relationship
“Reading [my] physicians’ notes...I found only a few brief descriptions of how I felt or looked, but there were copious reports of the data from tests and monitoring devices. Conversations with my physicians were infrequent, brief, and hardly ever reported.”

The Narrative – The Patient’s Story

- Rich in history
  - Context of illness, treatment, decision-making
  - Subtle details of each patient’s unique circumstances
- Preserves humanistic elements of physician-patient relationship
- Promotes clinical reasoning - Opportunity for review, reflection, reasoning, reassessment
Categories of Deficient Notes
3. Inaccurate Documentation

- Copy/paste – facilitates documentation of outdated and conflicting information
  ✓ “Day 7/14 of vancomycin…. WBC count improving… antibiotics completed today”
- Weight and vitals may differ depending upon where they are documented
  ✓ Affecting weight-based dosing of medications
Categories of Deficient Notes

4. Deceptive Documentation

- Irresponsible
  - Intentional – fraud
  - Unintentional – lack of attention or concern
- Template facilitates documentation of an element (history, ROS, exam) that was never assessed/performed
- Copy/paste a colleague’s note without attribution
Categories of Deficient Notes

From the ACP Case Files:

An elderly woman was admitted to the hospital for a GI bleed. The admission exam listed:

Rectal exam – unremarkable

Hematology consult requested. While obtaining the patient’s story, the consultant discovered that no one had performed a rectal exam.

GI documented “hemorrhoidal bleed,” but had not performed a rectal exam. The patient was seen by 6 physicians during her stay. The patient was subsequently diagnosed with rectal cancer.
Drivers of Poor Documentation

- Time constraints
  - Measures
  - Reimbursement
    - Software
    - Medicolegal concerns
The Imperative

The sorry state of clinical notes

- Bloated
- Inaccurate
- Without story
- Loss of the patient

Not an irreversible state!

*The Burning Platform – Time to Jump*
The Imperative for Addressing the Current State of Notes

- Excessive information
  - Importation of multiple labs and imaging reports
  - Importation of irrelevant problems, past history
  - Distracting, cumbersome, time-consuming

- Insufficient information
  - Lack of a narrative of the course of a patient’s illness
  - Lack of a sense of the patient as an individual and their social context, concerns, priorities
The Imperative for Addressing the Current State of Notes

- Programs that confine data entry into specific fields - Suppresses clinical critical thinking
- Use of the computer for documentation - Physician multitasking, decreased attention, decreased meaningful written communication
- Decreased patient-physician interaction and decreased patient satisfaction (and likely physician satisfaction too)
Improving Documentation

- An unstoppable force?
- Change starts from within
  - Identify the drivers in your practice
  - Commit to improve
  - Impacts patient care
  - Impacts learners/trainees – you are a role model
Clinician Accountability

- Be proactive. Be responsible!
  - Making a difference is an active process
  - Expand our circle of influence

- Local efforts
  - Group practice
  - Hospital
  - Education – students, residents, fellows
To Own or Bemoan the Problem?
Clinical Documentation in the 21st Century – ACP Policy Paper

- Objective - Improve the quality and value of clinical documentation and better use documentation to improve care
- Methods - Literature review and input from College leaders and non-member experts
- Describes:
  ✓ Evolving purposes of documentation
  ✓ Drivers
  ✓ Opportunities and challenges from EHRs
- Proposes guiding principles and actions – For clinicians, institutions, technology vendors, regulators, payers

ACP POLICY PAPER – Primary Purpose

- Primary Purpose of the Note
  - Support patient care and improve clinical outcomes
  - As value-based care models grow - primary purpose remains facilitation of seamless patient care to improve outcomes while contributing to data collection that supports analyses
  - Structured data - captured only where useful in care delivery or essential for quality reporting

- Physicians’ Role - Work with their care delivery organizations and medical societies to define and improve local standards and systems

ACP POLICY – Templates & Shortcuts

- Templates – Allowable, use judiciously!
  - Can facilitate thoughtful review of previously documented info
  - May improve completeness/efficiency of documentation
  - Most relevant for elements using standard terms (e.g., ROS)

- Copy/Paste - Allowable, with caution!
  - Can be used if information is accurate and adds value
  - May improve accuracy (decreased transcription errors), completeness, efficiency
  - Can jeopardize accuracy (failure to update) and the quality of care

THE 10 COMMANDMENTS OF ELECTRONIC DOCUMENTATION

1. Remember the primary objective - Communicate clinical findings and reasoning to the healthcare team

2. Tell the patient’s story – Evolution and contributing factors to the condition and management options

3. Be concise

4. Be accurate - Avoid creating or perpetuating documentation errors

5. Do not copy/paste without attribution
6. Use templates judiciously
7. Include supplemental data only when adds value
8. Avoid unhelpful or redundant text
9. Consider using “APSO” format (Assessment & Plan / Recommendations first)
10. Commit to improvement - Provide/receive feedback from peers, engage in your local EHR optimization efforts
TAKE HOME POINTS

- Work with IT departments on projects on how to improve poor EHR design
- Be aware of requirements to insert items for quality review purposes
- Be conscious of time constraints and find ways to work efficiently
- Follow the 10 Commandments (tell the patient’s story, be concise, be accurate)
- Commit to improve - Join ACP in recreating a culture of high expectations for clinical documentation
A final reminder

“The clinical record should include the patient's story in as much detail as is required to retell the story.”