FEATURE

The Physician Waiting Game (Room): Documentation Burdens Mount for Clinician Leaders Nationwide

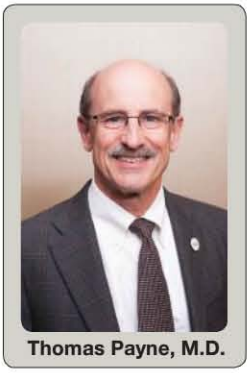
As EHRs have become commonplace, physicians are left wondering when documentation within them will become simpler

BY RAJIV LEVENTHAL

On May 29, the EHR-2020 Task Force of the American Medical Informatics Association (AMIA) issued a report with recommendations on the status and future directions of electronic health records (EHRs). In the report, several of the recommendations, including the very first one, target cutting down on the amount and complexity of documentation clinicians have to do.

Undoubtedly, as more continues to be asked of physicians now than perhaps ever before, clinical documentation remains a huge burden for them. At the time of the task force report, Thomas Payne, M.D., medical director of IT services at University of Washington Medicine and chair of the task force, told *Healthcare Informatics* that the reason the report focused on that area is because it is causing a great deal of problems in practices. "Providers are very vocal in describing the burden this poses to them. And people who go to see those providers are also noticing that they don't get the attention and focus that they used to," Payne told *HCI*. "They see their doctor and nurse staring at a computer screen. It is lengthening the days of providers, interfering with the interaction that people have with providers and taking providers away from what they do best. That is why it is in the first set of recommendations."

Indeed, the report's first recommendation was to "simplify and speed documentation." The report noted, "Although medicine requires an entire team to care for patients and to document the care patients receive, Centers for Medicare & Medicaid Services (CMS) requirements have placed the primary burden of office visit documentation on physicians. Information entered by other care team members and patients should be as valued as information entered by the physician."


Thomas Payne, M.D.

In a more recent interview with *Healthcare Informatics*, Payne expands on this thought, noting that other people, including patients, are qualified to enter information into the note. "The patients are the experts on how they feel that day, and other providers [other than the one in the room at the moment] are on the care team also," Payne says. "They should be entering information that they know best and have that be sufficient for that part of the documentation. This way the burden is not solely on the provider who is in the room with the patient for that moment." Payne's driving point here, as outlined in the AMIA report, is that physicians' time investment in patient care documentation has doubled in the last 20 years, by some measures, possibly consuming up to half of a physician's day.

TECHNOLOGY FLAWS

What's more, the introduction of EHRs has only magnified these problems and the amount of time providers spend on documentation, Payne says. In one large survey, the task force noted, staff internists reported that EHRs take an extra 48 minutes of their time per day compared to manual systems.

Indeed, while EHRs can facilitate and even improve clinical documentation, their use can also add complexities and challenges. The "single most common issue that most physicians and other providers have about the current EHR state today is documentation," Payne

says. He gives an example of when a cancer screening is needed. He says that often the documentation for the screening—that has occurred somewhere else—is entered by the provider in the exam room when it could have flowed from the source of the screening test directly into the EHR without any requirement for re-entry. "We need to return the patient visit to its value, which is to listen to a person's concerns, perform the relevant exam, and take the relevant history down," Payne says.

At the same time, many physicians have argued that the quality of the systems being used for clinical documentation is inadequate. To these points, earlier this year, the Medical Informatics Committee of the American College of Physicians (ACP) outlined seven recommendations related to clinical documentation within EHRs and five suggestions related to EHR design. While many of the ACP recommendations are broadly based, atop its list was that "patient care support and improvement of clinical outcomes should be the primary focus of clinical documentation software."

Additionally, when the American Hospital Association (AHA), in conjunction with Newtown Square, Pa.-based Executive Health Resources, part of the Optum family, launched a Clinical Documentation Improvement Trends Survey in February 2015, one of its main findings was that the design of some EHRs can turn a physician encounter into an exercise in data entry. Also, the survey found, there are often patient details that are crucial in accurately representing the complexity of a case and delivering quality care but that don't neatly fit into one of the EHR's fields. This design flaw in EHRs can unintentionally prevent that crucial information from being documented in the patient's medical record and instead just noted in the physician's mind. Advancements in technology that leverage natural language processing and computer assisted coding can be an effective solution to address the documentation gaps prevalent in EHR systems, according to the report.


Vivek Reddy, M.D.

As such, EHRs have become a double-edged sword when it comes to documentation, says Vivek Reddy, M.D., CMIO of the Health Services Division of the UPMC (University of Pittsburgh Medical Center) health system. "EHRs facilitate an over-reliance on putting in large sequences of text, or documenting detailed physical exams with a click, and unfortunately, that doesn't force you down the path of why you're documenting what you're documenting in the chart," Reddy says. "EHRs speed to create good billing notes but not good communication notes. They sort of messed up our center points."


Trenor Williams, M.D.

Jonathan Teich, M.D., CMIO at the Amsterdam-based academic publishing company Elsevier, and an emergency physician at Boston's Brigham and Women's Hospital, agrees with Reddy in that EHR tools have been developed around the documentation requirements, so a lot of the details are constrained. "For some elements of the encounter, we need a change in the specifics of the documentation requirements before the EHRs can make changes," Teich says. However, he does note that some EHRs are built much more with clinical workflow in mind; they make it easy to combine putting documentation in with getting information out that you need right away, such as well-organized test results, prior notes, and important new events. Those systems serve the physician as much as the physician is serving them, he says.

Payne says there are lots of other ways to enter information into the system beyond the keyboard and the mouse. "There is ample room for innovation; the use of voice should be greater than it is today, in addition to other technology that we aren't even thinking of now," he says. "There isn't a single solution for everyone, so do what's most comfortable for you. We can solve this problem as we have very bright people who have incredible technical skills and vivid imaginations," he says.

BACK TO SQUARE ONE

The AHA/Executive Health Resources survey further found that the primary barrier prohibiting physicians from being effectively engaged in clinical documentation improvement is a lack of understanding of the importance of strong documentation, as reported by more than 66 percent of survey respondents.

Trenor Williams, M.D., managing partner, Clinovations at Washington, D.C.-based The Advisory Board Company, says that there is an opportunity at the health system level to step back and get clinicians around the table to talk about how they want each other to document to improve patient care. That, he says, will effectively help transitions of care across settings. Williams, a former family practitioner and CMIO, says there is also an onus on physicians to figure out what the right information is about a patient, and what needs to be in the note. "What is absolutely relevant? Why did I make adjustments about the

assesment and plan? You need to make sure that clinicians are able to get the story of the information there rather than extraneous information," Williams says.

At UPMC, a pioneer health system when it comes to many physician quality and IT initiatives, Reddy says that when the organization pulled physicians together last year and asked them what their main purpose of documenting was, it quickly realized that clinicians have lost their way in the value of why they write their notes. "The answers gravitated towards reasons such as billing and getting paid. So we needed to re-focus and re-set the bar to say the reason you're writing this note is not for billing, but to document the care you're providing in the best and most specific way as possible," Reddy says. "We used that guiding principle to re-train our provider community on how to write a note and why to write a note. We had to undo the urban myth that the only thing you write notes for is to get paid," he says.

Specifically, Reddy adds, UPMC broke down every type of note a doctor writes, including the history and physical, and the progress note, into individual subcomponents. They then decided what would be the design principles about what sort of data they would automatically import in a note. "What parts of a note did we want? You have structured data and unstructured data, so what would we allow to copy forward day-to-day or note-to-note? We re-configured all of our note templates to meet those standards we set," he says.

By setting those standards, UPMC was able to do a subjective analysis based on the length of notes, and it saw if there was cut-and-paste or copy forward taking place. "We saw some good results, including at least a 33 percent reduction in length of notes just by applying these principles," Reddy says. The clone note problem started to go away; the only sections in the note that were pulled forward from note-to-note, he adds, noting that they also saw active note editing.

Certainly, "note bloat," referring to the overwhelming amount of information in a note that makes it challenging to pull out the key pieces, is a real problem for physicians and significantly impacts documentation quality. According to Williams, what has happened is that progress notes in the hospital setting are now six pages long rather than three-quarters of a page, like they used to be, when printed out. That's because it brings in an entire 36 hours of labs or the entire medication history, he says, and is thus not represented visually and concisely as it could be. "It's good information, but does it need to be part of every progress note? Probably not," Williams says. The impact of note bloat, or copy-and-paste, is simply inaccurate data with the potential of patient safety repercussions, adds Michelle Troseth, R.N., Elsevier's chief professional practice officer. "If you are relying on a colleague's notes with inaccurate data, it could be [dangerous]."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MORE THAN MANDATES

On Oct. 6, the same day that CMS would unveil its EHR Incentive Program final rules, during a joint meeting of the federal Health IT Policy and Health IT Standards committees, committee members raised concerns about the clinical documentation burden imposed by the plethora of quality reporting programs. For one, as reported by *Healthcare Informatics*, Patricia Sengstack, chief nursing informatics officer at the Marriottsville, Md.-based Bon Secours Health System, said that many nurses in her organization complain that their nursing admission assessments take almost two hours to complete for each patient. "I had a student count how many clicks it took to fill it out, and if you filled out everything, the total comes to 537 clicks," she said. She asked if there were any plans at the federal level to shrink all the required documentation.

Karen DeSalvo, M.D., National Coordinator for Health IT, responded that, among other things, the U.S. Department of Health & Human Services (HHS) needs "to see if there are ways we can streamline quality reporting to make it seamless so there is e-quality measurement and think about the documentation burden component of that

so we are linking these clicks to outcomes." Kate Goodrich, M.D., director of the quality measurement and value-based incentives group at CMS, added that the documentation burden is an issue CMS has heard a lot about. "We have tried to address that in a few ways," she said, "but perhaps we should set specific targets. With meaningful use measures and what is required for documentation, in our proposed rule we have proposed a significant reduction in terms of what has to be documented. We are trying to be responsive to exactly what you are saying," she said.

"On the quality measure side, one of the things we absolutely could have done better in Stage 1 and Stage 2 of meaningful use is to have involved the front-line providers—meaning the nurses who actually do the entry of data as well as the front line physicians and EHR vendors—in development of measures with an eye toward not only having the right kind of measures, but ensuring that the logic relates to the work flow is created in such a way that we minimize that burden, and we did not do a very good job of that in the first couple years. Part of that is because we took administrative claims measures and retooled them," Goodrich admitted.

A nurse herself, Elsevier's Troseth says that when a patient who is discharged comes back in, the nurse has to start the documenting from scratch. As such, in many organizations, Elsevier has implemented a patient intake tool to help with the patient profile. "If the patient was discharged, I can pull it up and build on it, rather than start from

Clinical Leaders Discuss SOAP vs. APSO

For years, clinician notes were written in the logical SOAP (Subjective, Objective, Assessment, Plan) format, which made sense when everything was written on paper. However, clinicians have recently argued that this format translates poorly from paper medical charts to the EHR. As such, a newer design, APSO (Assessment, Plan, Subjective, Objective) has been introduced and since debated in clinical circles. Proponents of APSO say that since the assessment and plan are at the top of the note, and are readily located when the EHR note is opened, it makes for a smoother format. For this story, *Healthcare Informatics* asked clinical leaders their thoughts on the two formats.

Thomas Payne, M.D., medical director of IT services at University of Washington Medicine: The APSO approach puts the thinking of providers' and the recommendations up front. This is a very reasonable approach that some like and others don't. I see a role for it personally, since it helps you get the information you want more rapidly. Another way to reach the same objective would be for notes to be more succinct. If the reporting information you see—the subjective and objective— are to the point and succinct, that makes it easier to read through them and then see the plan and assessment that follow. But really, it's up to the provider.

Jonathan Teich, M.D., CMIO, Elsevier, and ER doctor at Brigham and Women's Hospital: I don't particularly favor a switch to APSO. Understanding the patient context as expressed in the present and recent history and exam is very important to me as an emergency doc; it helps me create a mental image of the patient, so I can better absorb and critically review the assessment and plan when they come up next.

Trenor Williams, M.D., managing partner, Clinovations, The Advisory Board Company: APSO was a reactive response to note bloat and having six-page long notes. The idea is that you ideally want the assessment as the most important thing to see. What do I think is going on with the patient and what's my plan? Putting that assessment in facilitates effective transitions. Most organizations that we work with still are using SOAP more often than APSO, but I see a more continuous lean towards APSO.

Vivek Reddy, M.D., CMIO of University of Pittsburgh Medical Center's (UPMC) Health Services Division: At UPMC, we were legitimately split on this and couldn't come to a decision, so we brought it to our executive steering group. SOAP has since remained our standard. Our notes have become so much shorter by not auto piloting large amounts of content that's already available in the EHR. So by notes becoming shooter, people can get to the assessment and plan without scrolling or hunting for it. So we ended up sticking with SOAP, but we can always revisit it.

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scratch. It saves a lot of time and is interdisciplinary. It makes the patient feel better and ensures team collaboration," Troseth says.

Nonetheless, UPMC's Reddy says requirements need to be less about capturing a physician note or piece of physician documentation for every visit, and more about good documentation from any caregiver that is participating in the care for patient. "As we move into a population health model of care, episodic notes and counting notes done by doctors as meeting requirements for meaningful use is not where we should focus our energy," Reddy says. "This overemphasis on an X percentage of encounters needing to have an electronic note doesn't add anything to where we're going."

A PATIENT-FILLED FUTURE

In 2010, more than 100 primary care doctors from Boston-based Beth Israel Deaconess Medical Center (BIDMC), Danville, Pa.-based Geisinger Health System, and Seattle-based Harborview Medical Center began sharing notes online with their patients via a secure patient website. Each site was part of a 12-month study to explore how sharing doctors' notes may affect healthcare.

Patients reported feeling more in control of their health, being better prepared for their visits and several other benefits. Doctors saw little or no impact on their work flow. In the five years since the launch of the study, the number of patients who are able to read their visit notes has grown to more than five million nationwide.

While both patients and doctors showed enthusiasm, it should be noted that some doctors also expressed concerns. They wondered if note writing would become vaguer knowing that patients would be reading the notes. The doctors also worried about how patients would define mistakes, how patients would report errors and ultimately, how that process might impact trust.

At the University of Washington Medicine, Payne says everyone in the system has been participating in the OpenNotes movement for the past year, and "it's the right direction for the country to move in." He says that there is the option to have certain very sensitive notes, where clinicians might feel that the exposure to the note is more harmful than beneficial, but he adds that this is very rare. "Almost all of our notes are open for the patient to view just as soon as they are signed by the note author," he says.

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Meanwhile, across the country at UPMC, Reddy says that the organization is on board with the movement, but in certain areas, is treading carefully. For instance, he says that the organization has a potential problem when family proxy members who have access to the note want to view it. "Sometimes a sensitive note could be for a patient, but we can't subdivide the content of notes," Reddy says. "Say I am talking about an example of physical abuse or drug/alcohol use, I can't subdivide that micro part of a note to not be seen by a proxy member that has access to it. So for us, the physician community is embracing it in pockets [only] right now," he says.

Reddy adds that one thing that could make OpenNotes even more interesting, which he has seen in other organizations, is when the physician and patient build the note together during the face-to-face interaction. This way, he says, there is no mystery in the content of the note. "In these circumstances, the transparency is complete, the loop is closed, everyone knows what's in there, and there is a joint agreement to put it out there," he says. When doctors are doing delayed documentation or dictation the next day, for example, the challenge becomes not knowing what that content of the note will look like, and that makes both doctors and patients nervous, Reddy adds. "We see it from both sides," he says. "If we thought every doctor's note that was getting created was a verbatim scribe of what actually happened in the interaction, it would be a whole different ballgame. But we're not there yet. We haven't ripped the Band-Aid off across the board." ◆