The Resource for HIT Leaders   B. Chaiken

HealthData
Management

The Latest

HIT Think Why it's time to reconsider a documentation vision for EHRs

By **Barry P. Chaiken, MD**
Published **December 15 2016, 3:36pm EST**

More in **EHR, HIT, Clinical data repositories, Clinical decision support, Medical practice management**

Remember the blue book? Starting as early as junior high school, teachers handed out that pale blue 8-by-8-inch booklet when each student had 50 minutes to handwrite as fast as possible everything they knew about a particular subject. Urban legend suggested teachers issued grades based upon the number of pages filled rather than the content contained in the illegible scribble.

Handwriting does not allow for cut and paste. There's no verbatim copying from multiple pages of Wikipedia to "enhance" spontaneous brilliance. The essay length was determined by the knowledge of the student and the quickness of the pen.

Before healthcare information technology (HIT) and electronic medical records (EMR), clinicians wrote their notes similarly. Limited by the strength and stamina of their dominant hand, and their knowledge of the patient's condition, clinical documentation represented a singular clinician's assessment of the patient. When written well, these notes followed the format designed by Larry Weed, MD, more than 50 years ago—the problem-oriented medical record—that included for each problem subjective and objective descriptors coupled with an assessment and plan (otherwise known as SOAP notes).

The introduction of EMRs over the past decade completely changed the way we write clinical notes. No longer limited by our hand-driven writing speed, our notes reflect typing speed, and more importantly the functionality of the EMR used for documenting care.

Templates help structure clinical notes with prepopulated descriptors that are easily modified through pull-down lists. Often, laboratory and other electronically exchanged data points automatically fill these templates, further expanding the clinical note. In addition, cut and paste functionality enables the wholesale duplication of other parts of the medical record and insertion into a separate author's clinical note.

Although a more detailed note provides better clarity of the medical condition of a patient, patients do not have just one clinical note in their medical record. Every clinician—physician, specialist, nurse, therapist and resident—writes notes. Inevitably, note writers record similar patient findings and lab values, copy text from documentation already contained in the medical record, and detail assessments and plans already recorded.

While a heavily documented written medical record provides the reader with clues to its complexity by the thickness of its binder, digital medical records offer no such visual clue. Considering the ease with which digital documentation can be generated by caregivers, it is unclear whether inclusion of the byte size of the clinical notes would effectively indicate the complexity of a patient's illness the way thickness does for paper medical records.

Although EMRs offer access to clinical notes, they offer no sense of the number of notes or the volume of clinical note pages. Skimming through the record to access the important clinical content is inherently more difficult because of the volume of notes and the frequent repetition of identical findings, assessments and plans created by each individual caregiver.

Blaise Pascal, a French mathematician, logician, physicist and theologian wrote in 1656:

"Je n'ai fait celle-ci plus longue que parce que je n'ai pas eu le loisir de la faire plus courte.' or roughly translated as 'I have done it longer because I did not have the leisure to make it shorter."

This phrase, also attributed to Mark Twain and T.S. Eliot, clearly summarizes the documentation dilemma facing clinicians using EMRs to write their notes. As all are pressed for time, they utilize the fastest means possible to complete their note with the most information. Like Pascal, they do not have the time to succinctly

formulate the note and remove less important or distracting patient data documented elsewhere, but rather make it "plus longue" rather than "plus courte."

For researchers, the problem of bloated records presents a real challenge. In 2014 at the Digital Healthcare Conference in Madison, Wis., researchers and informaticists sounded the alarm that the digital data stored in medical records may not be valid. The frequency in which information is copied from one note to the next creates a simple means for inaccurate information to permeate a medical record. Similar to unsubstantiated rumors posted at extreme websites becoming mainstream news, false information entered into a medical record—when copied over and over by other documenters—can become truth from fiction.

When Dr. Weed proposed the problem-oriented medical record, typical notes consisted of only a few sentences with little structure that meant nothing to anyone other than the note's author. At that time, more documentation meant better informed caregivers across the clinical spectrum.

With the advent of EMRs, the explosion of notes creates an environment where there is too much documentation rather than too little. As the time available to focus on each patient diminishes, clinicians experience little time to review all available notes to become informed about a patient's current condition. Therefore, clinicians make choices on what they review and what they dismiss, leaving the needed access to critical patient information left to chance.

To effectively utilize EMRs to manage patient care, organizations must seek ways to decrease documentation by embracing processes and policies that reduce redundant information. Unlike the final philosophy exam in college, shorter prose jam packed with critical facts delivers more value than drawn-out descriptors that offer limited value in patient care.

Informaticists do not currently know what works best to decrease the size of notes, and therefore the documentation burden on clinicians. Alternatively, they do know that excessive documentation leads to bloated medical records that obscures important patient information. Potential solutions to reducing documentation bloat require close evaluation.

Removal of the cut and paste function within EMRs offers one option. Streamlined structured templates in lieu of free text notes offers another.

A radical solution, the unified clinical note, deserves serious consideration. The unified note requires all clinicians—physicians, nurses, pharmacists, therapists—to write their notes in the same place within an EMR. This clinical note format creates a narrative that becomes an ongoing, longitudinal description of the patient's condition, assessment of the patient, and expression of the current care plan.

A unified note ensures that all those providing care access the same information while encouraging a reduction of duplicative data entry. It also lessens the documentation burden of everyone connected to care delivery.

The positive impact of patient centered medical homes and specialized, procedure-focused surgical teams illustrates that modern medicine requires a diverse clinical team approach to efficiently deliver high quality care. Perhaps a team approach to clinical documentation is the next step in making the documentation process both high quality and efficient.

Barry Chaiken is the president of DocsNetwork Ltd. and has more than 25 years of experience in medical research, epidemiology, clinical information technology, and patient safety. He may be contacted at bchaiken@docsnetwork.com.

Barry P. Chaiken, MD

Barry Chaiken is the president of DocsNetwork L   as more than 25 years of experience in medical research, epidemiology, clinical information techn   nd patient safety. He is board certified in general preventive medicine and public health and is a fellow, former board member, and chair of HIMSS.

More from this Author

Why unified notes could lessen documentation times

Why the Personal Grid may be the best way to share records

How MACRA will shift providers' IT efforts