The Pen is the Tongue of the Mind

Developing a Strategy For Computerizing Provider Documentation

Clinical documentation is very personal. How we document as clinicians reflect our thoughts, decisions and efforts in treating our patients. Regardless of the structures established by our professions and the medical records departments of our healthcare organizations, we each have developed a unique way of approaching a patient’s chart, culling through all the detailed information contained in it and a style of writing that communicates our findings, opinions, recommendations and questions about our patients. As legislative and compliance regulations increase and re-imbursement measures become more rigid, we are experiencing more and more standardization around clinical documentation. Add to that the roll out of advanced clinical information systems in both the inpatient and ambulatory care settings, and it is not surprising to hear physicians, nurse practitioners and physician assistants complain that provider documentation is just another casualty to cookie-cutter, cookbook medicine.

Nursing initially faced the challenge of standardizing and automating clinical documentation 20 years ago in response to the nursing shortage of the 1980s. We were looking for a way to decrease the amount of indirect patient care time associated with documenting and we developed checklist charting, exception charting and other pre-configured templates that allowed us to quickly but concisely document our care plans, interventions and patient outcomes. While some pioneering hospitals used nursing information systems to automate these templates, most hospitals created and implemented paper tools. Over the years, this manual approach have resulted in a more uniform nursing documentation methodology and have positioned hospitals well for the roll out of automated nursing documentation as part of the electronic medical record (EMR).

Even though HIMSS Analytics™ EMR Adoption ModelSM reports that only 1 percent of US hospitals have achieved Level 6-MD/Provider Documentation in their EMR roll out, many hospitals are getting ready to move forward with automating provider documentation in the inpatient setting. The introduction of EMRs in clinics and physicians’ offices has removed some of the “fear” factor associated with automated documentation. Many hospitals have piloted provider documentation in specialty areas such as the ICUs or EDs, and are now ready to tackle computerized documentation on an enterprise-wide level. Today, we don’t have the luxury of time to standardize provider documentation on paper first and a key factor in successfully automating provider documentation will be a well-defined strategy.

I know that “doing a strategy” may be perceived by some as waste of valuable time, but the depth and breadth of provider documentation is so broad, some effort has to be spent on defining the scope and level of standardization the organization is ready to pursue. When one considers that provider documentation may include hand-written and electronic documents, audio and video tapes, emails, faxes, photographic and drawn images, observation charts, check lists, management and shift reports and clinical anecdotal notes that span all medical specialties and sub-specialties, a well thought out provider documentation strategy becomes a critical success factor in moving forward.

As with all strategic planning efforts, developing a provider documentation strategy includes establishing the guiding principles, conducting the current state assessment, defining the future state vision, developing strategic recommendations and creating the tactical implementation plans.

Documentation and record-keeping are fundamental parts of clinical practice. It demonstrates the clinician’s accountability and records their professional practice. It is important when developing the guiding principles of computerized provider documentation that we balance idealism with pragmatism and flexibility.
with structure. Standardizing and automating provider documentation needs to be an evolutionary process. How it is introduced may differ dramatically from its eventual enterprise-wide deployment. Guiding principles that seem to resonate well with clinicians are ones that keep documentation focused on the patient, not on forms or data, that encourage clinicians to build on each other’s contributions and expertise without duplicating efforts or capturing redundant information and that balance the ability to free text with capturing codified information in a way to support patient care, research and education. The bottom line is that a computerized documentation system needs to communicate to the interdisciplinary care team the care patients are receiving and support defined frameworks of practice, which make clear the responsibilities, competencies and evidence based knowledge for which each member of the care team is accountable.

Having done my fair share of clinical information systems strategic planning projects over the last twenty years, I have always felt that too much time is spent on doing the current state assessment. To me, the primary value of understanding what you do today is in being able to determine the magnitude of change that will be required to achieve the future state you are driving towards. I still believe this to be true in most planning efforts – but not in planning for automating provider documentation. For this planning process, I believe that it is imperative to understand fully how clinicians currently document. As I said before, I believe the way we document is very personal and will require a major change in behavior. In order to achieve that change we need to fully understand and respect the current state. Observing clinicians while they document and interviewing providers about their readiness to change are key activities in assessing the current state. Very often, their concerns are not so much about changing their documentation methods but are directed towards the logistics of access to the system, availability of hardware alternatives, managing a hybrid paper-electronic record during the implementation and how system downtime will impact patient care delivery.

Once we understand the processes of clinical documentation, we need to understand the tools currently used. To fully understand how clinicians chart, an inventory of all documentation tools needs to be gathered. In organizations where there is a strong medical records committee that approves all forms and templates that are included in the medical record, this is a large but manageable task. Contacting the forms vendor for an inventory of medical records templates is a good way to begin. Be aware, however, that the vendors understand that compiling this inventory is the first step towards automation and they may be less that anxious about getting this information to you in a timely manner. In organizations where the medical records committee is less prescriptive, providers and departments may have developed their own electronic templates using word processing software. I have had the experience of working with organizations where residents carried their templates on jump drives, documented online and then printed the documentation out and put it on the chart. Inventorying charting tools in this type of environment can be a daunting task, but one that must be done. Once all of the current templates are collected and cataloged, they need to be reviewed for information consistency. Many of the specialty forms capture the same information and will present opportunities to standardize much of the information across all clinical specialties.

It is also imperative to understand how much of the manual documentation eventually makes it to the “legal” medical record and what components of the electronic record will be incorporated into the final medical record. One of the key activities in defining the future state of computerized provider documentation is identifying enterprise-wide information elements and specialty-specific information elements. Consensus needs to be reached not only on what data elements will be universally captured across the inpatient setting but how will each element be collected. It is during this phase of planning that organizations set the boundaries for how much free text information will allowed versus how much of it will be codified. Many healthcare systems that had initially allowed a large percentage of automated clinical documentation to be free text found that it was next to impossible to go back and mine data for quality and safety information. And while they found it easier to get providers to use the documentation system initially, they found it very difficult to get them to migrate to more codified data later on. Many of the organizations that went down this path recommend biting the bullet and going with as much discrete data collection as possible from the beginning. Adoption may be more difficult at the onset, but the long term benefits of being able to mine clinical information outweigh the initial resistance.

It is also important to document a plan on how the remaining paper components of the record will be managed and stored so that the future state vision includes all aspects of the current manual record.

Once the future state is defined, a set of strategic recommendations needs to be developed. These include deployment strategies—pilot projects versus house wide implementations, initial use by residents, NPs and PAs verses getting attending physicians to use the system, rolling out general documentation functionally versus specialty functionality. The organizational culture, physician leadership and champions and clinical system functionality will all play major roles in developing these strategic recommendations. We also need to develop a well defined change management process so we can quickly respond to and implement changes in documentation functionality based on care deliver needs as well as regulatory and billing. Once the recommendations are approved, we need to develop detailed implementation plans to move forward.

This is an exciting time in healthcare IT. The clinical community, the public and our government are looking to clinical information systems to help address many of the challenges in healthcare today. We aren’t going to get many chances to bring clinical automation to providers; we have to do it right the first time. I believe having a well-defined provider documentation strategy gives us a much-needed leg up in achieving this success. JHIM

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