HIT Policy:
Clinical Documentation

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Why Focus on Documentation

- Takes a lot of time
  - ~10% of physician time in inpatient setting, ~20% in outpatient
  - Substantial time for nursing and others
  - Multiple uses but those who document not focused on secondary uses
- How you document probably much less important than whether is electronic
  - Dictate, free-text, structured
  - None of three clearly superior
  - Tools to extract knowledge like natural language processing so good that they can soon be almost seamless
- Documentation clearly linked to measuring quality
  - Historically mostly done through chart review
  - Want to collect as byproduct of care

Documentation Paradox

- Lots of information locked away in electronic text
  - Or even worse, on paper
- Structuring could have major downstream benefits
  - Especially re clinical decision support
- But if you structure too much, people won't use it!
- Options
  - Structure anyway
  - Structure a bit but allow lots of flexibility
  - Use techniques like natural language processing to understand key issues

How Physicians Document in Outpatients

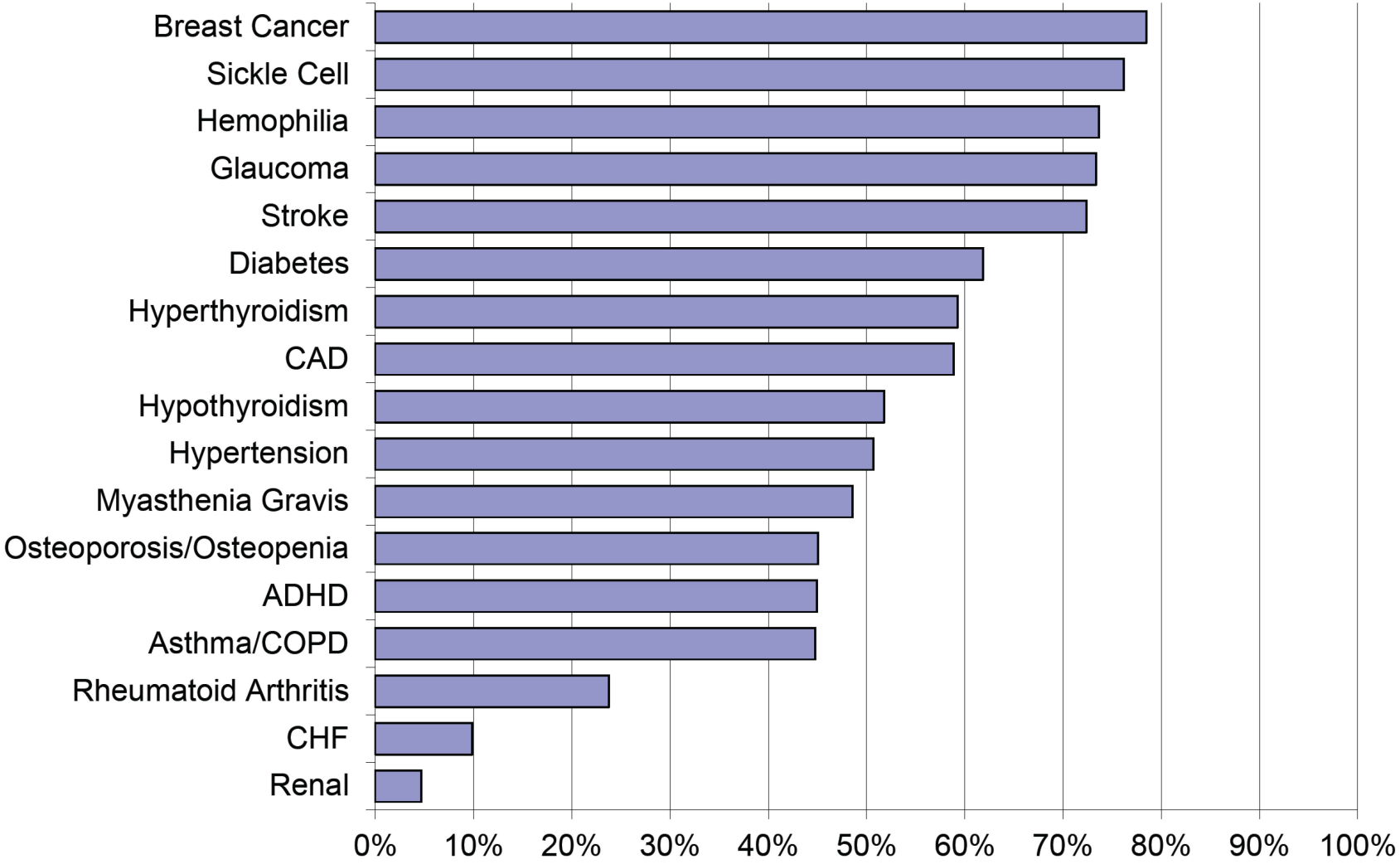
- 1088 physicians studied
  - 85% of physicians used just one method
  - 49% templates, 22% dictation, 13% free form, 16% no predominant method
  - Difference between PCPs and specialists
    - PCPs: 60% templates
    - Specialists: 38% dictate
  - Most physicians were satisfied regardless of approach used

Pollard SE et al, Int J Med Inform 2013

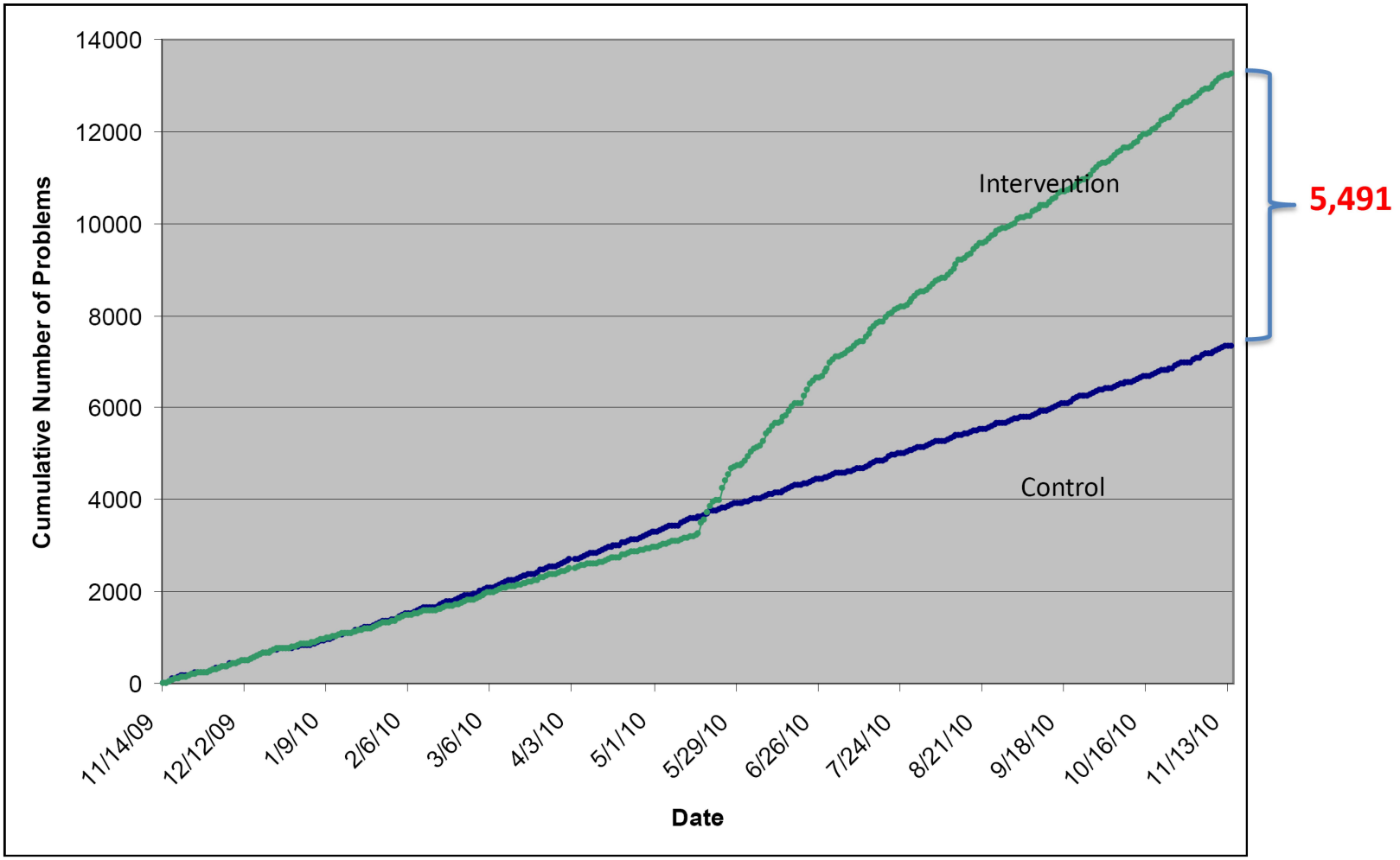
Documentation Method and Quality

- Evaluated 112 physicians, 71 PCPs, and 41 specialists seeing patients with diabetes and coronary artery disease
- For general internists, overall quality was no different whether providers used template, free form, or dictation ($p=0.52$)
  - Also no correlation with note quality (PDQI) score
- For specialists, quality scores were high for those using templates or free form vs. dictated ($p<0.001$)
  - Note quality score also slightly higher on PDQI ($p=0.03$)

Problem List Completeness



Addition of MAPLE Problems



Wright et al, JAMIA, 2012

Leveraging Electronic Clinical Documentation to Decrease Error Rates

- Providing access to information
- Recording and sharing assessments
- Maintaining dynamic patient history
- Maintaining problem lists
- Tracking medications
- Tracking tests
- Ensuring coordination and continuity
- Enabling follow-up
- Providing feedback
- Providing prompts
- Placeholder for resumption of work
- Calculating Bayesian probabilities
- Providing access to information sources
- Offering second opinion
- Increasing efficiency

Schiff and Bates, NEJM 2010

Key Policy Issues

- Having notes documented electronically is valuable for a plethora of purposes
  - Thus suggest requiring that they be made available electronically but not to specify how
    - Still learning about best ways to document
    - Relationships between modes of documentation and quality are uncertain
- Require collection of key items for quality
- Desperately need rationalization of payment rules because these have driven documentation in irrational directions