



Practical Steps for Meaningful Physician Documentation in Healthcare

A White Paper from Webmedx

Practical Steps for Meaningful Physician Documentation in Healthcare

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Executive Summary

One of the biggest roadblocks to successful adoption of EHRs is electronic physician documentation, specifically clinicians' use of point-and-click, structured templates.

While hospital administrators and chief information officers (CIOs) prefer full utilization of the EHR's structured documentation capabilities over narrative reports, physicians struggle with capturing the complexity of their patients' stories within drop-down menus and checkbox templates. Perhaps this is why only 0.7% of hospitals nationwide have achieved HIMSS Stage 7 EMR Adoption¹, the point at which the majority of physicians must document via point-and-click templates within the EHR.

This white paper explores new, practical options for physician documentation that improve provider satisfaction while also generating structured data for EHRs. By utilizing the methods outlined in this document, healthcare organizations can make steady progress toward complete EHR adoption, reduce overall documentation costs and support physicians' satisfaction.

Flexible choices for data capture that are familiar and completely integrated into the EHR workflow are a win-win for physicians and the healthcare organizations they serve.

62% of physician reports are still created using dictation and transcription in HIMSS Stage 6 hospitals.

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A Physician Documentation Paradox: Productivity versus Structured Data

Health Information Management (HIM) professionals and CIOs face a serious challenge: how to balance physician productivity, satisfaction and preferences with the need for structured, discrete data and meaningful EHR adoption.

Physicians simply speak faster than they type, up to 400% faster. According to the Association for Healthcare Documentation Integrity (AHDI), nearly 1.2 billion clinical records are produced annually in the U.S. If all of these reports were converted to template-based capture it would cost America's healthcare system nearly 80 million hours of physician productivity every year.

Medical dictation and transcription, the fastest way for physicians to document their encounters, now includes the ability to convert a doctor's spoken word into discrete data. Everything a doctor speaks can be mined and converted to discrete data formats for EHR fulfillment and secondary data uses. By using discrete, minable transcription solutions, clinician time is saved and EHR adoption is accelerated.

For physicians, every minute counts and lower physician productivity is an unintended consequence of template-based documentation. As an example, Robert Clare, M.D., Virginia Beach, Virginia, reports a 30% drop in efficiency and now spends five hours of each eight-hour emergency room shift performing basic data entry.ⁱⁱ The Medical Transcription Industry Association (MTIA) and Mark Anderson, FHIMSS, CPHIMS, and CEO of AC Group, also report that it takes physicians nine times longer to enter data into structured templates instead of dictating their reports. Finally, the urge for physicians to simply "copy and paste" introduces a new challenge for patient safety and compliance.

Conversely, CIOs face a technology challenge. The establishment of data reporting infrastructures is paramount to support core measures reporting, meaningful use attainment and more. Productivity must be balanced against new data reporting requirements. It's a difficult balance to achieve and even harder to maintain.

Transcription's Relationship with the EHR: Reality versus Perception

Over the past decade, most EHR return-on-investment calculations have included the assumption that physicians would adopt template-based documentation and medical transcription costs would be significantly reduced or eliminated.

However, provider organizations that originally hoped to eliminate 100% of their transcription as a byproduct of the EHR have discovered that approximately 30%

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Mark Anderson, FHIMSS, CPHIMS, CEO of AC Group

When based largely on a reduction in transcription costs, EHRs almost always fall short.

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of transcription still remains. One such organization, Fallon Clinic in Worcester, Massachusetts, was only able to reduce transcription costs by a third, far lower than the 75% reduction projected by their EHR vendor.ⁱⁱⁱ

In a brief web-based survey of HIMSS Analytics Stage 6 EMR hospitals, it was revealed that a variety of report capture options are being used including speech recognition, voice recognition and structured EHR templates. Hospitals in the survey averaged 35% use of structured templates within the EHR, 62% dictation / transcription and only 4% voice recognition. Mayo Clinic in Jacksonville, Florida, a renowned leader in quality healthcare and innovator in technology adoption, still has 70% of physician notes created using dictation and transcription according to Andrea M. Seymour-Sonnier, Director, Appointment and Transcription Services. Furthermore, while the use of structured templates is growing (currently 25% of total notes are created using structured templates), over 720 dictators still use the organization’s medical transcriptionist and editor services.

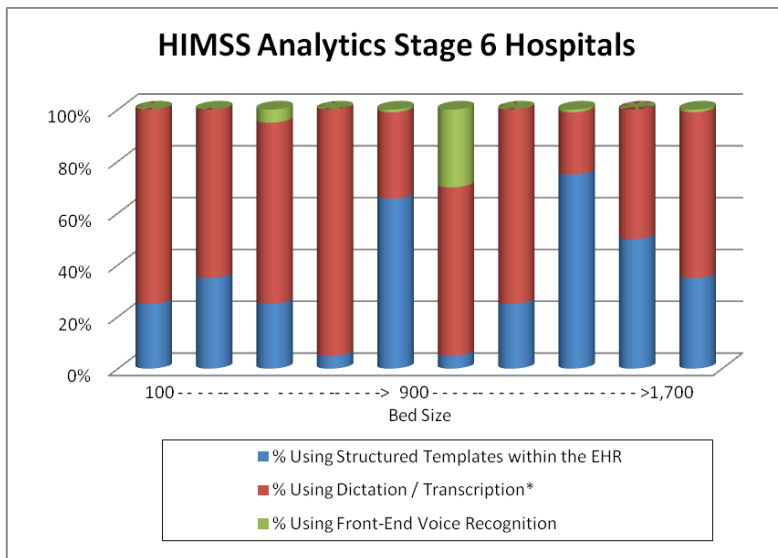


Table #1: Physician Documentation in HIMSS Analytics Stage 6 Hospitals

With the blended approach to physician documentation, different modalities are used to capture dictation based on physician choice, practice patterns and document types.

A Blended Approach Offers Physician Choice alongside Discrete, Structured Data

For these organizations and thousands like them, a blended approach to physician documentation appears to be the norm. This hybrid, blended approach is the only model proven to work and will probably be the most ideal for physician documentation needs in the foreseeable future. Most importantly for CIOs, new data mining capabilities of transcription and speech recognition technologies allow for electronic data mining of discrete, structured data from narrative reports.

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With the blended approach, different modalities are used to capture documentation based on physician preference, practice patterns and document types. For example, structured history and physical templates populated by a physician assistant may be used in one care setting while a dictated and transcribed narrative report may be the best documentation method for inpatient discharge summaries, encounter notes, findings and assessments. Front-end and back-end speech recognition options are also embedded within the same physician profile, giving physicians the best of all worlds.

Physicians use templates where and when they make the most sense but also have the option for narrative reporting to capture the entire patient story. For example, high-profile revenue and risk areas such as cardiology and urgent care have unique needs and have historically dictated lengthy patient histories to ensure that all of the necessary details are documented.

It is important to carefully weigh the benefits of EHR templates against physician productivity, patient care, transcription costs and revenue. By doing so, providers can enable the streamlining of processes without sacrificing the unique facts that impact quality patient care.

The consensus among physicians is that the EHR gets high marks for readability, accessibility and data analysis while the narrative dictation and transcription provide a more complete and accurate picture of care.

Speech Recognition Saves Money for Providers

According to the Gartner Group, today's dictation and transcription solutions are in the final phase of a three-phase evolution. In this stage, front-end speech recognition is used by physicians to create narrative reports with three options for document editing: physician real-time self-editing, scheduled self-editing, or editing by a medical editor (back-end speech recognition). Also termed "once-and-done," third-phase solutions support physician choice and provide a new, critical capability: data mining discrete information from narrative dictations.

"Phase three is where real impact for patient care takes place relative to benefits for improving patient care and addressing ARRA meaningful use reporting," mentions Michael W. Davis, former Executive Director, HIMSS Analytics, and current Managing Director, The Advisory Board Company.

Reports created using front-end speech recognition save healthcare organizations up to 60% per report in transcription costs. With the average urban hospital generating 600 reports a day, that's a significant savings and one that providers can't afford to overlook.

Once the report is edited and finalized by the physician, data can be mined and made available for secondary uses such as clinical decision support system input, EHR data fulfillment and other reporting requirements—including meaningful use. As more and more reporting requirements arise, data derived

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from narrative reports (termed Narradata™) will bridge the gap for organizations that haven't yet implemented structured physician documentation templates, but are still required to submit quality-related data.

Minable narrative reports, whether speech-generated or dictated and transcribed, optimize the physician's time and allow for the structured details to be reported. Providers should look for these capabilities when evaluating and selecting transcription technology along with the vendor's overall ability to integrate with clinical decision support systems and EHRs.

Practical Use Before Meaningful Use: Helping Physicians Manage Change

The constant tug-of-war between practical use and meaningful use slows EHR adoption and hinders organizational success. This harsh reality has led to a new, more practical approach to clinical documentation; one where transcription continues alongside the EHR, instead of being replaced by it.

Having moved from traditional dictation and transcription to editor-based models and subsequently the once-and-done approach, third-generation systems blended with structured templates have three distinct advantages:

- Supports physicians' natural workflow
- Facilitates better physician adoption
- Achieves faster meaningful use of the EHR

This blended approach is particularly beneficial as physicians are slowly introduced to template-based reporting. Instead of suddenly forcing physicians away from all narrative transcription, they should be given a choice of input options including front-end speech recognition, back-end speech recognition and traditional dictation. The focus is on the use of information to improve quality, cost and performance rather than the technology itself, a concept endorsed by AHIMA in their April 2009 statement on meaningful use of EHRs.

Conclusion

EHRs simplify access and sharing of patient information, facilitate automated order entry, and support better clinical decision making through evidence-based care plans. However, much like paper workarounds make electronic records more useful, the inclusion of narrative documentation options such as speech recognition and medical transcription within the EHR makes them more practical; and easier for physicians to adopt.

As more and more reporting requirements arise, data derived from narrative reports (termed Narradata™) will bridge the gap for organizations that haven't yet implemented structured physician documentation templates, but are still required to submit quality-related data.

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Instead of forcing physicians to change, Webmedx offers flexible, integrated solutions such as speech recognition, voice recognition and traditional transcription all within a single physician workflow. With PhysicianChoice™, physician workflow is streamlined, not interrupted. Physician satisfaction is improved and EHRs are advanced.

Furthermore, the QualityAnalytics™ application from Webmedx gives CIOs the ability to abstract structured, discrete data from transcribed reports for a variety of secondary data requirements including core measure and meaningful use reporting. Webmedx truly delivers the best of all worlds to physicians, CIOs and the healthcare provider organizations they serve.

For more information about Webmedx's physician documentation, quality analytics or medical transcription service solutions visit the company's website at: www.webmedx.com or call the company directly at: 877-846-1200.

***With PhysicianChoice™,
physician workflow is
streamlined, not
interrupted.***

About Webmedx

Webmedx, Inc. is the premier supplier of medical documentation services for hospitals and clinics nationally. Recently named 2009 Best in KLAS for Outsourced Transcription according to the 2009 Top 20 Best in KLAS Awards: Software & Professional Services report, December 2009, the company designs and implements customer-centric documentation solutions using the most credentialed domestic workforce in the industry and its own enterprise-class, intelligent speech recognition and content management technology platforms.

**2009 Best in KLAS Awards: Software & Professional Services report. Available online at: www.KLASresearch.com.*

ⁱ HIMSS Analytics EMR Adoption, January 2010. Available online at:

http://www.himssanalytics.org/hc_providers/stage7Hospitals.asp

ⁱⁱ "Letters to the Editor", The Atlantic, November 2009, pg. 16

ⁱⁱⁱ "Measuring ROI", Baldwin, Gary. Health Data Management, May 2009. Available online at: www.healthdatamanagement.com