Current State of Clinical Documentation in the Electronic Health Record

S. Trent Rosenbloom, MD MPH

Professor and Vice Chair of Biomedical Informatics
Professor of Internal Medicine, Pediatrics & Nursing
Director, My Health at Vanderbilt Patient Portal

National Academies of Sciences, Engineering, and Medicine

Workshop on Health Disparities in the Medical Record and Disability Determinations

Trent.Rosenbloom@VUMC.org

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- I have no conflicts to disclose

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Clinical Documentation

- Creates a record of observations, impressions, plans, and activities from clinical care
- Generally tied to encounters between patients and clinicians or a healthcare organization
- Can consist of notes and/or data points

- The earliest punchcard-based computers included tools to capture clinical documentation

Drivers of Clinical Documentation

- Support communication among clinicians
- Justify reimbursement
- Accommodate regulations
- Create a legal record of what happened
- Database clinical findings and information
- Drive teaching & education, decision support
- Support quality assessment

Lots of Ways to Document

- Templates that structure, import, replicate
- Typing narrative
- Voice to text & dictation/transcription
- Clicking on structured items
- Task shifting to scribes, patients, others
- Collaborative & wiki-based approaches
- Increasingly ambient and AI
- Good old-fashioned handwriting

The 'How' Influences

- Structured data entry improves reuse but can be inexpressive and inefficient, maybe inaccurate
- Narrative data entry maximizes expressivity and story telling, but can impede reuse
- Templates can create massive notes – a snapshot of the EHR – that are unreadable
- Lack of integration into the interface and workflow can drive documentation burden

Documentation Burden

- Outpatient physicians spend 16 minutes interacting with the EHR per patient
- 11% of this time is spent after hours, weekends
  - Often called *pajama time*
- Nurses now spend 19-35% of their shift time documenting, up from 9% when on paper
- Hospital nurses document an average of one data point every 49-88 seconds

Documentation Burden

- Not all documentation is burdensome
- An imbalance between EHR usability & satisfaction and the clinical & regulatory demands of creating EHR information
- Associated with clinician burnout, increased medical errors, hospital acquired infections, and decreased satisfaction

We Are Left With Complexity

- No clear standard for high quality documentation
- Busy burdened burning out clinicians
- Numerous conflicting demands on notes, data
- Varying, evolving technology and tools

…and yet: with EHR-based tools, good, complete, expressive notes & structured data can improve care quality and efficiency

Clinical Documentation Use & Reuse

- Dr. Del Fiol – The challenge of bias in EHRs and clinical documentation
- Dr. Adler-Milstein – How to pull SDOH information from clinical documentation
- Dr. Vydiswaran – How to leverage narrative documentation, including with AI