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HIT Think Why unified notes could lessen documentation times

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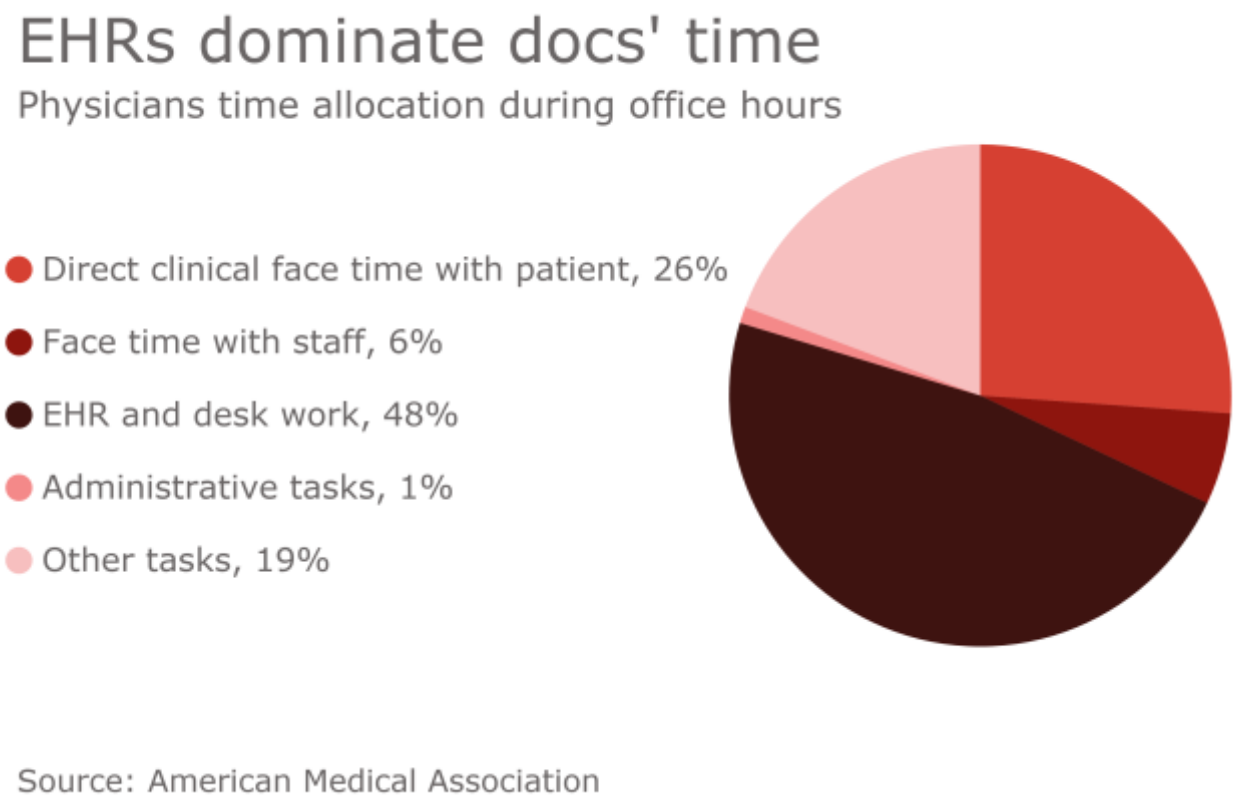
In 2009, an article in Methods of Information Medicine reported that physicians spend 26.6 percent of their time documenting care and 27.5 percent of their time in direct patient care. In their conclusion, the authors wrote, "Computer-based tools and, in some areas, documentation assistants may help to reduce the clinical and administrative documentation efforts."

More recently, an article by Sinsky et. al. just published in the Annals of Internal Medicine reports that physicians spend 49.2 percent of their time documenting care and 27 percent of their time on direct patient care. When in the examination room with patients, physicians devote 52.9 percent of their time on face time with patients and 37 percent of their time on electronic medical record (EMR) work. The physicians in the study also reported that they spent one to two hours each evening performing patient documentation.



Clearly, the future predicted by the authors of the 2009 article did not come true. It appears that EMRs increase the amount of time physicians need to invest in documentation at the detriment of the time spent interacting with patients.

Does increased documentation improve outcomes? Does it reduce costs? There exists scant evidence that either of these are true.

Perhaps to effectively leverage EMRs to better deliver care requires a reworking of clinical workflow and other processes. Or perhaps the EMRs themselves require a rewrite to better enable clinical workflows. Nevertheless, EMRs and their application as a documentation tool appear to interfere with direct patient care, reducing the time physicians have to interact with their patients.

As the use of EMRs in documentation requires intensive review, so does our approach to documentation itself. With our use of a variety of connected medical devices and sensors (often described as the Internet of Medical Things) a plethora of patient information automatically becomes part of the EMR and documents care. The requirement of clinicians to

document test results and other measurements now appears a redundant exercise, as this information flows directly into the record via interoperability software.

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Before healthcare information technology (HIT) and EMRs, 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 (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.

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, resident—write 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.

A radical solution, the unified clinical note, deserves serious consideration. The unified note requires all clinicians—physicians, nurses, pharmacists and 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, too.

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