Q&A Electronic health records

Clinical Documentation Improvement Week

As part of the fourth annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. ***Daniel R. Smith, RN, CCDS, CDIP****, has been a nurse for more than 22 years, and a CDI specialist for six years in large teaching hospitals. In addition to a degree in nursing, he has experience in healthcare information technology, a background in healthcare informatics, and experience serving EHR companies as a traveling implementation consultant; he is also preparing to earn certification in CPHIMS and HL7. Smith answered the following questions regarding electronic health records. Contact Smith at* Daniel.Smith2@DignityHealth.org.

Q ***Where does your facility stand regarding implementation of an electronic health record (EHR)?***

A ***Within our large system of hospitals, there are facilities still in the process of transitioning from paper charts to EHRs.*** At my facility, we are principally all electronic with a small percentage still scanning in paper records. There is a difference between EHR and EMR. EMR is a standalone electronic record that is dedicated to a primary care physician's office, clinic, or a single hospital such as in a rural area. An EHR is a larger network, a systemwide electronic record that can span multiple hospitals, clinics, and doctors' offices.

Results from a recent ACDIS poll "Has your EHR improved physician CDI adoption and query response rates?" indicates hospitals are overwhelmingly still on paper. However, "meaningful use" regulations, which provide financial incentives from CMS to implement EHRs, will no doubt drive all hospitals to become 100% electronic eventually. Yet meaningful use occurs in stages and is a very complex undertaking.

There are many advantages to having the entire country 100% electronic beyond improving the quality of patient care and safety—for example, a centralized national database.

Q ***Who is your EHR vendor, and can you describe the effectiveness or shortcomings of their software?***

A ***We use a vendor widely known in the industry. It has all the principal elements of what you would expect:***

- Computerized physician order entry (CPOE)
- Lab results
- Nursing documentation
- Medication administration (eMAR)

Every EHR, no matter how well engineered, will have its pluses and minuses. An EHR is in constant flux with modifications and version upgrades, patches and updates, to meet the ongoing changes and needs of the organization and its stakeholders.

A great model to use in the planning, development, implementation, maintenance, and improvement of any system is the "three-legged stool" approach—the three legs being people, process, technology. The idea is that you must have all three under consideration and fully addressed to have a well-oiled EHR running efficiently. Leave any one element out and the system just doesn't work that well.

Another wonderful feature that many hospitals are integrating in with their EHRs is the CDSS (Clinical Decision Support System). Meshing CDI documentation data elements into a CDSS can also help remind physicians of common documentation requirements and

potentially decrease query rates. This, in turn, enhances the performance of computer-assisted coding (CAC) on the back end, more seamlessly creating an electronically empowered medical record.

Does your EHR allow for electronic queries/ prompts to the physician, and if so, has electronic querying been beneficial for your CDI specialists?

We have a dictionary of "canned" queries available in a drop-down menu; once completed, they go to the physician's message folder in the EHR. This works relatively well for us. However, one thing commonly overlooked is user adoption. User adoption ties back into the process leg of our three-legged stool. Five minutes of a physician's time is extremely valuable. If the process is not user-friendly, they find shortcuts or ignore the process all together.

Many physicians face challenges interacting with electronic queries. How well electronic queries are configured can make a huge difference in CDI outcomes as it will be also be an indicator of user acceptance.

Two basic forces drive everything in healthcare IT—standardization and interoperability. Without these two dynamics in healthcare IT, EHRs would not exist. ICD-10 and the efforts of CDI are examples of standardized data. Yet CDI faces a double-edged challenge in not only user acceptance for EHRs, but the acceptance and adoption of the CDI programs themselves.

So it is imperative that physicians and CDI staff or managers are included in system design and development. If users do not adopt a technology because the workflow is not user-friendly, they will find a workaround such as "batch" signing e-forms, which can be a fast way for the physician to clear an inbox, but counterproductive for CDI efforts since no information is actually filled out on the e-queries as a result.

You need to be as comprehensive as possible from the very beginning, including CDI so far as even in the project management scope for the RFP (request for proposal) when the EHR vendor is being hired.

Configuration and then the reconfiguration of new electronic workflows and functionality can be a big cost factor and needs to go through committees for approval. It's much more costly if changes have to be made after the fact. If the physicians feel CDI is a low priority and of little value, they will not engage in the process. The long-standing question we hear commonly is, "What is in it for me?"

Do your CDI specialists work remotely because of your EHR? How do their roles compare with those working on-site?

Our system has a few remote CDI specialists at the moment, but most are on-site. There has been discussion of changing this and allowing more CDIs to work remotely, perhaps a few days a week on-site and the rest of the week remote. I have heard of a few systems with 100% remote staff with at least one day a month on-site. This is possible in part due to the fact that they have achieved a 100% compliance response rate for queries. The organizational culture is not in a silo, it's 100% integrated.

Technologies are successful when they help eliminate divisions or silos. When those walls are broken down, it results in a more efficient, creative, and productive company. Healthcare is not an IT industry, but since healthcare is becoming so IT intensive, it's logical to adapt more of the business models that traditionally work in the IT realm to integrate what works for better outcomes. Like technology companies, healthcare is a service-intensive industry. So once healthcare facilities begin to operate more like these forward-thinking technologies, we will begin to see additional enhancements.

Is note bloat and copy/paste a problem in your facility, and if so, how are you working to combat it?

A principal need is always more time for doctors; it is extremely valuable to them and thus the temptation to copy and paste, it is an ongoing challenge. Stakeholders and administrators should understand this, and it should be discussed with IT to make the changes required, adding in hard stops and other such responses where they make sense. To that end, important stakeholders and users need to be invited or included in committees for system decisions and development.

CDI specialists should also be considered valuable stakeholders

in EHR design and functionality. On the other hand, when there is stakeholder resistance to changes in functionality such as copy and paste, it could jeopardize the overall health of the organization in the long run. The key is better workflow. Improving the physician workflow while also limiting or eliminating cut and paste would be an ideal solution; adoption to new EHR policies would then meet little resistance.

Seamless user interface with advanced technologies, such as with speech recognition software and Google Glass, are technologies that can help overcome copy and paste. An overwhelming consensus among doctors is that current first-generation EHRs are out of date, more or less "dumping grounds" and storage for data. IT-savvy physicians envision second-generation EHR with no keyboard or mouse—for example, having the ability to walk into a patient's room to document hands-free as they care for patients. Google Glass is an experimental cutting-edge example of how user adoption is being addressed by some hospitals. It saves the doctors time and is literally a hands-free seamless way to document while with the patient real time. Automation and the development of medical artificial intelligence is another way to ease the burden of ever-increasing demands of documentation on providers.

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