EXECUTIVE INSIGHTS

RESILIENCY + RECOVERY

CLINICAL DOCUMENTATION AND PHYSICIAN BURDEN

Aligning technologies with physician workflow

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Clinical documentation plays a critical role in providing, coordinating and paying for care. Efforts to reduce physician documentation burden create more time for patient care, help to improve physician engagement and enhance the integrity and quality of documentation. Knowing the impact of diagnoses on quality care measures and hospital value-based purchasing is critical to aligning clinical documentation reviews with changing reimbursement mechanisms. Improving the quality and value of clinical documentation ensures seamless care by other providers.

KEY FINDINGS

1. **Speech recognition software and scribes** can reduce physician documentation burden, but still require review and editing.

2. Real-time technology solutions can drive **physician prompts and rules** to improve the quality of care. Natural language understanding (NLU) technology can understand context, analyze unstructured data contained in a patient note and prompt physicians for clarification.

3. To combat note bloat, ongoing physician and midlevel provider training needs to **emphasize clear, concise clinical documentation** focused on medical decision-making and active management for the handoff to the next provider.

4. Poor use of the electronic health record (EHR) **copy-paste function** can affect clinical documentation quality by allowing the creation of internally inconsistent notes and resulting in lengthy notes that may obscure important information.

5. Hospitals and health systems are **customizing EHRs by creating rules and templates** to hardwire processes for transition care management and to ensure compliance with quality reporting.

5. **Alignment of incentives** across the organization is key when setting targets for quality improvement along with tracking and review of quality metrics in an integrated dashboard, and aligning quality and payment in physician contracts.

PARTICIPANTS

Kurt Barwis, FACHE
PRESIDENT AND CEO
BRISTOL HEALTH | BRISTOL, CONN.

Michael Bee
VICE PRESIDENT OF CLINICIAN SOLUTIONS
3M HEALTH INFORMATION SYSTEMS | PITTSBURGH

Jeremy Capps
HOSPITAL ADMINISTRATOR
ST. BERNARDS FIVE RIVERS | POCAHONTAS, ARK.

Stanley Frochtzwajg, M.D.
CHIEF MEDICAL OFFICER
COMMUNITY MEMORIAL HEALTH SYSTEM | VENTURA, CALIF.

Scott Goodfriend, M.D.
PHYSICIAN ADVISOR
COMMUNITY MEMORIAL HEALTH SYSTEM | VENTURA, CALIF.

Michael E. Henderson
CEO
TORII BEHAVIORAL HEALTH | COLUMBUS, OHIO

Ryan Speas, MBA
CHIEF FINANCIAL OFFICER
MACKINAC STRAITS HEALTH SYSTEM | ST. IGNACE, MICH.

Enoch (Nick) Ulmer, M.D., CPC, FAAFP
VICE PRESIDENT CLINICAL INTEGRATION AND MEDICAL DIRECTOR OF CASE MANAGEMENT
SPARTANBURG REGIONAL HEALTHCARE SYSTEM | SPARTANBURG, S.C.

Joseph Yallowitz, M.D.
VICE PRESIDENT AND CHIEF MEDICAL OFFICER
THE VALLEY HOSPITAL | RIDGEWOOD, N.J.

MODERATOR **Suzanna Hoppszallern**
SENIOR EDITOR, CENTER FOR HEALTH INNOVATION
AMERICAN HOSPITAL ASSOCIATION | CHICAGO

MODERATOR *(Suzanna Hoppszallern, American Hospital Association):* **What tools, services and processes has your organization employed to ease the documentation burden on physicians, and how effective have they been?**

MICHAEL HENDERSON *(Torii Behavioral Health):* What's helped us is the use of speech recognition software to document directly into our EHR. Our physicians can talk into a microphone instead of typing and that has sped up the documentation time.

Our EHR system was developed in house, and we continue to work on the connectivity with other EHRs. For example, we get most of our referrals from emergency departments, which means we don't have the level of connectivity that we need to check the lab results or the medical status of patients before they come in.

ENOCH (NICK) ULMER *(Spartanburg Regional Healthcare):* On the ambulatory side, we've been able to streamline a lot of our notes. I've been trying to work with our doctors to cut down the note bloat that we saw and modify the templates to make them more concise.

Speech recognition software has saved us a lot of time, too, because finding those boxes to click really slows us down. It helps if we can get into a field and transcribe something with natural language. Also, because of the new rule changes in the ambulatory space, the bullets, the check boxes and the number of things you must touch are not nearly as important.

We're trying to get physicians to focus on medical decision-making and telling the right story. Most of the templated world in which the physicians live will cover most of the requirements. But when you get down to the real essence of what's going on, it's the medical decision-making that is happening, what active management you're doing, and what your next step is going to be. I tell the physicians to think in ink as much as possible, but don't give me lots of information that I have to go find.

We've tried to streamline their processes with speech recognition software for things like transition care management so that we have the hospital-to-home and home-to-office transition hardwired. We can use this technology to say, 'I need to review the discharge summary,' or 'The meds need to be reconciled.' We use that to guide the physician, because in the middle of a busy day, they might get missed.

SCOTT GOODFRIEND *(Community Memorial Health System):* The EHR is both a boon and a bust. With the EHR, it makes it so easy to copy and paste but, unfortunately, with the copy-paste function, clinicians forget the edit part, so misinformation is being transmitted throughout the chart, which gives it low credibility.

It's also a communication tool. Our consultants who use this health record may receive misinformation because the data that were transcribed for today were valid three days ago, but not today. It's so easy to take all the labs and all the X-rays and transport them to today's note. It becomes onerous for anybody to look at. Who's going to spend all that time to sift through and see what's important and what isn't.

I spend a lot of time teaching our residents and attending physicians to write a concise note with only pertinent information and to go through the thought process into why they're saying what they're saying. It's tougher with the attending physicians because they've learned things that they have to unlearn. The 'think in ink' thing is huge. It helps keep the note concise, easy to read for consultants so that it's better patient care.

Also, if our clinical documentation improvement (CDI) team can look at their thought processes in

a current note, it will make things more efficient and we'll have to bother the physicians less by saying, 'You approved an inpatient stay, but you didn't give the justification.'

STANLEY FROCHTZWAJG (*Community Memorial Health System):* Cut and paste has been misused, but I want to remind everybody that cut and paste is a tool. And tools can be misused. We would never take scalpels away from surgeons. We need to make sure that we train our surgeons properly and that they're peer reviewed. We also need to do the same thing with documentation so that people do it properly, not improperly.

MICHAEL BEE *(3M Health Information Systems):* Advancement in conversational artificial intelligence (AI) has enabled us to significantly improve the speed, efficiency and accuracy of clinical documentation at the point of care. Such physician-assistive technologies not only transform the physician experience by speech enabling the EHR but can also provide the platform for enhancements such as computer-assisted physician documentation (CAPD). CAPD can take speech recognition to the next level by providing proactive, real-time and automated insights within the EHR workflow. Innovating incrementally along this continuum, ambient clinical documentation solutions can make EHR documentation a byproduct of the patient-physician encounter and not a separate, burdensome task for the doctor.

KURT BARWIS *(Bristol Health):* We're paperless. We're a HIMSS Stage 7 validated organization, the highest adoption model measure for analytics maturity an organization can achieve. I think we're the first Meditech hospital in the country to do that. On the ambulatory side, we're not integrated, so we have eClinicalWorks cloud-based EHR software, but our clinical IT team has worked with all physicians to make documentation easier.

We've optimized effectively across the system and worked hard to reduce the documentation burden on physicians, but the prior-authorization requirements for surgery have gotten out of control.

Insurance companies want a peer-to-peer review with the operative surgeon to justify surgery as an inpatient and that is adding to the entire burden of burnout.

The more we excel at making this easier for physicians, at the same time, the requirements from the insurance companies are making it doubly hard for people. It's just that everything is a prior authorization now.

"I've been trying to work with our doctors to cut down the note bloat that we saw and modify the templates to make them more concise."

— Enoch (Nick) Ulmer — Spartenburg Regional Hospital

There's been tremendous progress in making documentation easier for physicians, at least from my perspective when I talk with physicians. The frustration and burnout are coming from all this onerous authorization process that requires their interaction.

MODERATOR: Kurt, thank you. We are hearing about the frustration with prior authorization from a lot of our members and the AHA is addressing it. Let's go to the next question. Does the clinical documentation effectively support care coordination and quality improvement efforts in your organization?

JOSEPH YALLOWITZ *(The Valley Hospital):* We've been using the EHR for more than 20 years. The expectations of improved efficiency and legibility, report writing and sharing of information have not been fully realized. This has led to much frustration.

The main issue we're having and one that we're trying to remedy is user friendliness. We are working on incorporating clinical decision-support

tools that will mimic the physician's workflow and assist in incorporating best practices.

There's a lot of potential. I think that we are paying the price for the next generation. It's already better than earlier versions. Right now, most of our staff see it as a burden that doesn't add much value.

With regard to quality initiatives, we do not have the same report writing capabilities that other industries have. So, we still rely on manual chart review. As the post-acute providers don't have our EHR, we are printing and sending copies of charts at discharge. We are working on reducing the amount of printing and making sure we send only the relevant information.

ULMER: We have a physician hospital organization and both independent and employed physicians, which gives us a chance to work with both sides of the spectrum. A few years ago, we started a streamlined Transitional Care Model (TCM) handoff process with our employed physicians. Pre-pandemic, we were able to help some of our independent practices implement the TCM. The independent physicians allowed us to send a direct fax of the discharge summary or the after-visit hospital summary to their fax machines. Central care coordinators made phone calls within two business days, and then our independent doctors made the appropriate handoffs to get the TCM visits done, and then ensure that those patients were seen in their offices. We hope to see decreased readmissions and a higher quality of care from that initiative.

The independent physicians told us how thankful they were because they saw value, and it was a quality win for us. It helped us move closer together on the hospital stays with some of our community providers.

MODERATOR: Michael, will you share some of the improvements you're seeing and what might be some quick wins in terms of clinical documentation technologies being applied to improve care coordination and quality improvement?

BEE: Timely, complete and compliant clinical documentation is the foundation for better medical communication, care coordination and patient outcomes. But innovative applications of natural language understanding technology can make a meaningful difference beyond its role in creating and improving clinical documentation. One such 3M application helps detect missed incidental findings and follow-up opportunities, and close gaps in patient care and revenue with embedded AI within the EHR workflow and work list by making unstructured data in narrative clinical documentation actionable. Nurse navigators can then triage the case, close communication loops, schedule appropriate follow-ups — and save lives. This is just one example of how advanced technologies applied to the right use cases can move the needle on care coordination and quality.

"Our goal with CAPD is to make it much easier for physicians to do the right thing at the right time, which in turn saves them rework and frustration later."

— Michael Bee —
3M Health Information Systems

YALLOWITZ: Several years ago, we worked on a performance improvement initiative to reliably order deep-vein thrombosis (DVT) prophylaxis on admitted patients. Our information systems team wrote a rule that prompted the admitting physician to order DVT prophylaxis based on the patient's risk factors. We were able to show improved compliance in ordering prophylaxis.

Our focus continues on improving the decision support for the physicians and information sharing for the entire care team.

BEE: Exactly, Joseph, our goal with CAPD is to make it much easier for physicians to do the right thing at the right time, which in turn saves them rework and frustration later. Physicians should never have to choose between quality and efficiency. By nudging clinicians on required specificity or toward reducing gaps in documentation and patient care, our CAPD technology helps minimize disruptive, retrospective queries to physicians and unifies their documentation workflows for better outcomes and user experience. But we have always believed that technology is never the end but merely a means to an end. It should simply be there when you need it without getting in the way.

ULMER: We are doing something similar on the ambulatory side. We are trying to do a better job of documenting the diseases from last year to this year and making sure we get the right specificity. Early this year, a reminder on the left side of the physician's screen showed the number of opportunities that were left out. Physicians rarely noticed it. In June, we made a big red box around that number and now 80% are reviewing the documentation.

"Our focus continues on improving the decision support for the physicians and information sharing for the entire care team."

— Joseph Yallowitz — The Valley Hospital

MODERATOR: What about technologies to support accurate payment and reimbursement for the care you provide?

RYAN SPEAS *(Mackinac Straits Health System):* Hospital administrators are pushing physicians to do more visits but, at the same time, they are demanding that providers increase the quality of their documentation. Our payment suffers with lack of documentation/information. We're missing key words, key diagnoses, things that we could bill for that we aren't.

We've tried several things. Currently, we're providing scribes, especially to those physicians who have been in the field a while. The downside is that most physicians will not accept what another person has written down for them without making sure that they read it carefully and then edit it, which puts them in the situation of spending the same time editing what somebody else wrote for them. How do we balance that? We also have tried voice recognition software.

The main flaw is that the industry wants it all, and then we add extra steps in the process such as prior authorization.

JEREMY CAPPS *(St. Bernards Five Rivers):* While there is some benefit to being able to run reports and see what's going on, it is a difficulty and burden for these providers and nurses to complete the documentation in a manner that would cover the financial aspects, as well as prove to the insurance companies that this care was done effectively.

MODERATOR: In your organization, how are you aligning physician performance and coordinating the needs of quality, case management, compliance and revenue cycle?

BARWIS: We've been on the positive side of the value-based purchasing system for years and now, just about every payer has a quality incentive.

We use a corporate goal as the CMS criteria. Currently, we want to have a positive gain in 60% of those criteria, so there is a key performance indicator dashboard that our board's quality committee looks at and tracks every month.

We are expanding the quality metrics, the value-based purchasing metrics, as an integrated dashboard across the system and making sure

that as we renew physician contracts that those incentives are integrated into what they're going to do and what they're going to drive.

ULMER: I agree with Kurt. We don't see the needle move if we don't align quality and payment in physician contracts. What we realized in the third quarter last year is that some of our numbers weren't moving as well as we'd like, and when we looked at our nurse practitioners and physician assistants and put them on the dashboard, instead of yellow and green, we saw mostly red.

We realized that a lot of the midlevel providers are seeing these patients, but we're not holding them accountable to the same level of quality. We are now providing education to them on blood pressure control, diabetes control and integrating in palliative care and advanced care planning. It must be aligned with the contract and be in a dashboard we can see. Physicians are competitive; they don't want to be in the red zone. If it makes clinical sense for the patient, we try to make it painless and achievable day in and day out. Then, let's put it in the contract and incentivize physicians to do even better. We've seen it work here and hope it will help us as we move into our midlevel.

BEE: Clinical documentation integrity (CDI) is the connective tissue between physician documentation and appropriate quality and reimbursement. A platform that supports both front-line physician workflows and backend CDI processes with shared clinical insights can help break silos in work streams and thought processes. AI can drive prioritization, automation and summarization of all the documentation in the encounter for CDI and quality teams. With the Hierarchical Condition Category risk-adjustment model, AI can also help optimize risk-adjustment factor scores and enable health care organizations to improve care quality and financial outcomes in the value-based environment.

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