AT THE CROSSROADS:
Clinical Documentation and the EHR

By Don Fallati, Altheus Advisors

The shift from volume-based reimbursement to value-based is a clear and well-documented imperative. Yet the industry mission to balance the cost/quality equation involves a complex array of mandates and initiatives. Under the newer value-based model, providers and healthcare organizations will have to ensure they thoroughly document patient information to justify treatments and demonstrate quality outcomes. The key to accomplishing these objectives is through complete and accurate clinical documentation.

Confronting the mission to produce the highest data quality possible is a core challenge in clinical documentation. We clearly need structured, codified, and normalized data that can be accessed and analyzed. At the same time, there remains a strong demand for the context, detail, and reasoning that unstructured narrative documentation uniquely generates.

The EHR has arrived at a critical juncture. The urgency to achieve the promise of these systems is requiring organizations to address the fundamental documentation challenge and overcome the realized issues slowing full EHR adoption – such as physician dissatisfaction, loss of productivity, increased time investment in documentation, poor usability, and increased risk.

What is the best path to generate structured discrete data while preserving context and clinical reasoning ideally captured through narrative?

One-size-fits-all documentation is not the answer.

Resolving the dilemma means managing a hybrid world in which a range of styles is not just tolerated, but also supported and optimized to create a rich, agile, and effective documentation environment. It is an environment that respects diverse workflows and fosters physician engagement, a critical goal in healthcare organizations.

The core strategy must begin by embracing the reality that different styles of documentation are best suited to different types of patient information. Some data is quickly and accurately captured in forms, fields, and templates; other information is only viable through narrative. The ideal system would automatically default to the best style/information match. Providing choice is thus not merely about user preference; it relates to more fundamental data realities.

A blended, hybrid approach to clinical documentation delivers many advantages, including:

- Returning time back to caregivers. Time is a physician's most valued commodity and more of it means more time for patients and clinical work.
- Preserving the narrative context and detail that is absolutely vital to data quality and the analytics that rely on such data.
- Making the EHR documentation experience far better for all healthcare professionals.

The journey to value-based care is complex and dependent on the highest quality information. Clinical documentation plays a crucial role on this journey. Why limit the tools available to use to generate rich, complete, physician-valued, and patient-friendly information? Supporting choice promotes narrative context, bringing the desired destination into view more quickly.

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MORE INFORMATION: Sign up for a complimentary webinar on October 29, 2015, and receive a copy of the complete white paper, entitled "At the Crossroads: Clinical Documentation and the EHR". Details available at www.winscribe.com.