Tackling Physician Burnout

by Making Documentation Easier

The modern electronic health record (EHR) is far from simply being a supporting tool in the delivery of care. The EHR has become the principal medium through which healthcare providers perform their most complex and critical professional responsibilities. Yet, even well-designed and efficient EHR components are often implemented poorly with substantial unintended negative consequences. As a result, the EHR has been implicated in numerous healthcare delivery challenges adversely impacting quality, safety and financial performance and exacerbating physician burnout.

Provider documentation — the core of EHR functionality and of the clinician experience in engaging with the EHR — is at the heart of the challenge of translating clinicians' physical workflow to an electronic medium. Clinical documentation captures all the key components of care delivery and the patient's experience with the healthcare system and enables a wide range of critical business processes. This includes care delivery and coordination, coding, charge capture, and care quality and patient monitoring. However, the very rapid pace of EHR implementation, stimulated in large part by regulatory forces, made it difficult for many organizations to allocate the time and attention needed to configure the system to meet both clinician and business needs. Many health systems have been left with clinical documentation workflows that are inefficient and non-intuitive, and documentation that is inaccurate, fails to accurately capture the patient condition and does not reflect the clinical decision-making process of the providers. These shortcomings lead directly to iatrogenic error, unwarranted variation, duplication of testing and treatment, provider frustration and burnout, and often a sense of hopelessness and resignation to the inevitability of continuing to endure the current state.

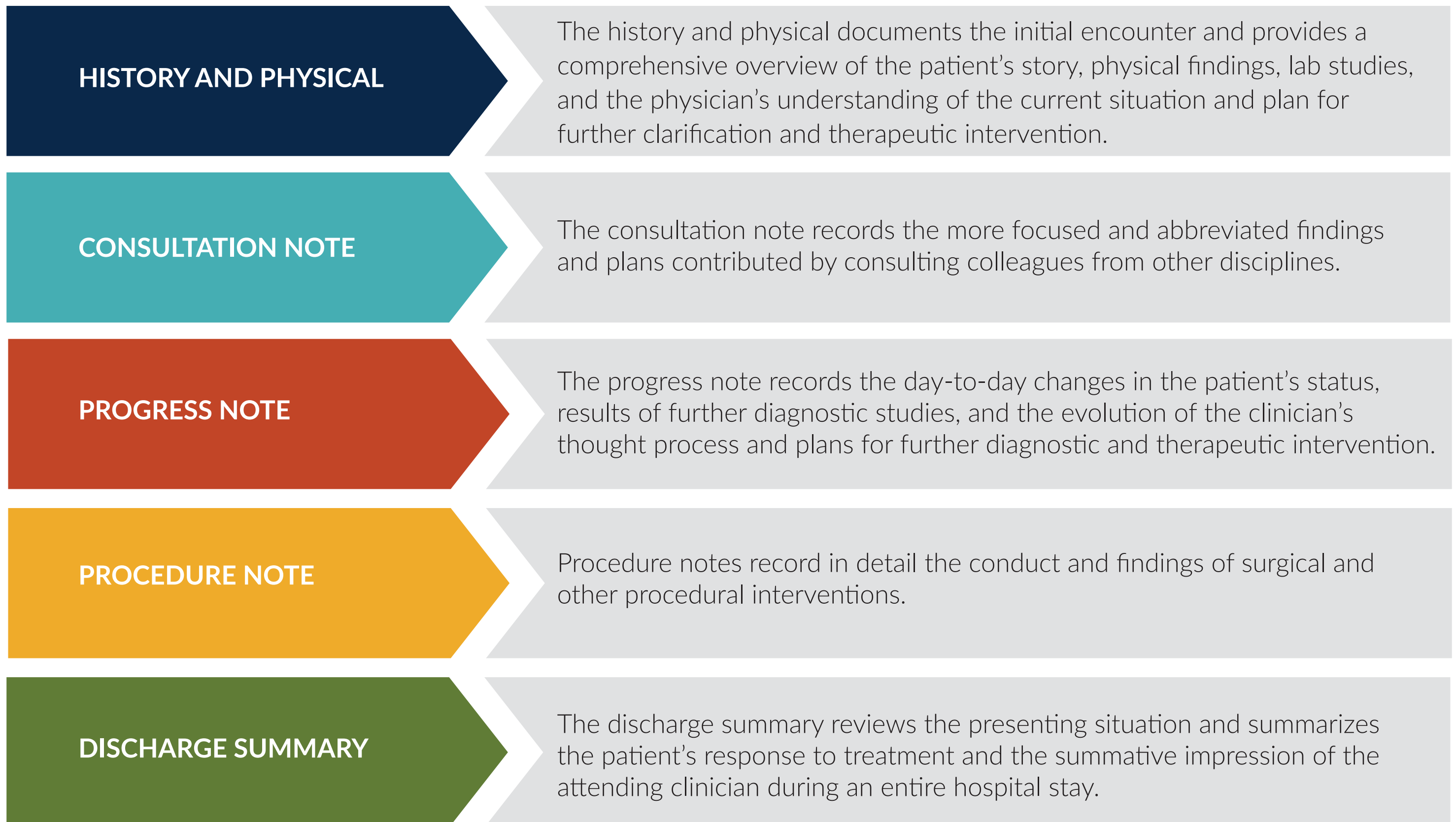
Few health systems have invested the time and resources to comprehensively revisit their provider documentation implementation and configuration because of the perceived magnitude of the challenge.

Contrary to prevailing belief, remediating physician documentation is not insurmountable. Successful outcomes can be achieved by employing a physician-led process that appropriately involves all stakeholders and addresses the foundational technical and cultural drivers.

Using an interdisciplinary, structured, standard-setting and design approach, **health systems can make material strides in reducing the EHR-related drivers of physician burnout** and improving documentation, collaboration between physicians and business stakeholders, and physician engagement and satisfaction.

Drivers of Inefficient and Ineffective Provider Documentation Workflows

Provider documentation in the EHR follows the traditional framework and sequence used long before computerized systems were available. When this time-honored workflow is properly followed, the documentation succinctly and effectively depicts the entire episode of care:



However, several characteristics of EHR implementation and use have contributed to inefficiency and ineffectiveness of provider documentation workflows:

The Challenges of Initial Implementation

The implementation phase of an EHR is extremely challenging. The work is fast-paced, and the teams are often inexperienced in the finer points of the system's capabilities. The combination of enthusiasm for the new technology and inexperience in its use frequently leads to initial designs that have serious negative unintended consequences; oftentimes, the templates do not support specialty-specific workflows or include evidence-based prompts to support the organization's care models and value-based care.

Failure to Optimize

As organizations gain experience with their EHR, there is opportunity for optimization and ongoing cycles of learning with the goal of being a best-practice user of the technology. However, implementation of an EHR is often seen as a destination rather than a starting point, and organizations fail to plan and resource for optimization. As a result, providers are left with a basic documentation tool that does not meet their needs or address the specific nuances of capturing patient care data (i.e., specialty areas). In addition, optimization efforts are commonly shortchanged due to budgetary constraints, the distraction of other initiatives, and ongoing cycles of upgrades and enhancements. This leads to providers developing individual workarounds to get through their care delivery activities and indefinite deferral of optimization work.

Lack of Support for Personalization and Expanded Provider Proficiency

Immediately following EHR training and implementation, providers reach an initial peak of proficiency in the use of the EHR. With structured efforts to systematically enhance the provider community's capabilities in the use of the EHR, further progression to higher levels of proficiency and use of advanced EHR capabilities can result. Unfortunately, few organizations undertake such an organized and deliberate effort, and clinicians revert to subsistence levels of EHR use, typically with less long-term proficiency than immediately post-live. This results in degradation in the quality of documentation due to inappropriate use of copy-paste, pulling in complete radiology and laboratory studies, failure to edit pull forward text and other maladaptive workarounds that providers employ just to get through their day.

Unidirectional Feedback from Business Process Owners

A subtle and often overlooked driver of poor documentation habits, particularly note bloat, is the steady, small but very consistent stream of feedback providers receive from business process stakeholders concerning their documentation. Medical Records, Coding, Quality, Safety, and Legal/Risk, all provide feedback to physicians about their documentation in the understandable and laudatory interest of capturing all appropriate revenue due to the organization and documenting required quality metrics to conform with external stakeholder requirements.

What is unique about this feedback is that it is almost entirely unidirectional. Providers often hear "if you include just this one additional piece of information, we can code at a higher level." Or they may hear "please document a little more about this particular clinical condition, so that we can achieve the right level of acuity." Providers rarely, if ever, are asked to shorten their note or create a more readable narrative. Consistent messaging for "more documentation" leads providers to believe that "more is always better," which predictably and consistently leads to note bloat and many of the other adverse documentation practices.

Interestingly, when asked about the impact of the "more is always better" style of provider documentation, the business process owners uniformly bemoan the challenges of reading these documents. Often Medical Records, Coding, Quality and others responsible for chart review and abstraction must hire additional staff due to the time it takes to extract meaningful information. When asked what would better meet their needs, the typical answer is "a clear description of why the patient is in the hospital, what is different in their care from yesterday to today, what the provider's thinking and plan are, and what is preventing the patient from being discharged today."

Compelling Benefits of a Comprehensive Provider Documentation Improvement Program

The reality is that many times the need for a provider documentation improvement (PDI) program emerges in relation to quality or workflow challenges. However, a comprehensive PDI program helps realize numerous compelling benefits:

- Achieving the expected business and clinical benefits of the EHR;
- Reducing adverse outcomes due to clinical documentation inaccuracy or poor usability;
- Improving physician satisfaction and engagement and a tangible way to demonstrate a commitment to more effectively aligning with physicians;
- Enhancing the physician experience and reducing burnout; and
- Improving the organization's reputation related to documents shared externally with other healthcare providers and documentation stakeholders.

The following questions shine light on scenarios that may benefit from an investment in provider documentation improvement:

- Are your physicians and other providers complaining of spending excessive time after clinical hours completing clinical documentation?
- Do your clinician and business process leaders believe that your medical records fail to accurately reflect the care your organization provides?
- Have you experienced adverse risk or liability outcomes due to the quality or completeness of your clinical documentation?
- Do your business process owners in Quality, Safety, Medical Records, Revenue Cycle or Legal/Risk complain about the accuracy, readability or usability of provider documentation?
- Have you or are you contemplating implementing Open Notes, sharing clinical documentation directly with patients? If so, are you concerned about the quality of that documentation in terms of patients' ability to understand it or how it may affect your organization's reputation in your patient community?
- Have you experienced significant error in the accuracy of your medical records due to inappropriate use of copy-forward or copy-paste functionality in your EHR?

7 Critical Success Factors for a Successful Provider Documentation Improvement Initiative

Successful provider documentation improvement initiatives must consider the complex drivers of maladaptive documentation and address the provider and business process operating requirements together. Doing so requires managing complex professional, cultural and change management needs and the core technical solutions.

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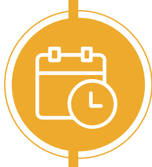
Laser-Like Focus. Provider documentation improvement initiatives are designed to engage clinicians in leading the entire organization to uniform, best-practice documentation standards. This is a quite different effort than traditional clinical documentation improvement initiatives that are focused on charge capture and revenue cycle priorities. While it is fully expected and likely that there will be positive acuity, charge capture and revenue results from a PDI initiative, it is essential that the clinical focus of these initiatives be clear to all stakeholders.

Provider-Led. A successful PDI initiative requires broad-based provider support and major change to established provider workflows. This can only be achieved by engaging the providers as leaders and owners of the initiative. Engaging with medical staff leadership early in the effort and identifying a broad base of physician participants are essential.

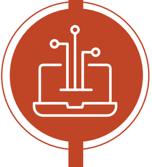
Multi-disciplinary Approach. While it is essential that the effort be provider-led, a successful PDI initiative will also require the input, expertise and agreement of a broad stakeholder base. Medical Records, Coding, Revenue Cycle, Quality, Safety and Legal/Risk all have important interests in provider documentation and should be included in the effort.



Efficiency with Provider Time and Attention. Creating a truly provider-led initiative requires the active and consistent participation of many providers whose time is limited and whose interest will quickly wane if their time is not spent in an authentic and effective manner. It is essential to employ meetings and activities that are highly productive, held at times that are convenient for providers and show rapid progress.

Development of a Consensus Style Guide. A critical work product of the PDI effort is the development of a consensus style guide addressing clinical documentation that applies to all clinical care providers who practice in the organization. The style guide serves as the foundation for the redesign of all clinical documentation templates and supports important change management functions of driving explicit consensus and surfacing disagreement among the provider representatives participating in the effort.

Feedback Mechanism. Based on experience, it is evident that while a style guide is necessary to a successful PDI initiative, it is in no way sufficient. Consistent, objective and accurate feedback to all providers on adherence to consensus documentation standards, provided by a trusted clinician colleague, is essential to the long-term adoption of new documentation standards, tools and techniques. It is important to create a review and feedback mechanism that is resource-efficient, practical to implement and sustainable over the long term.

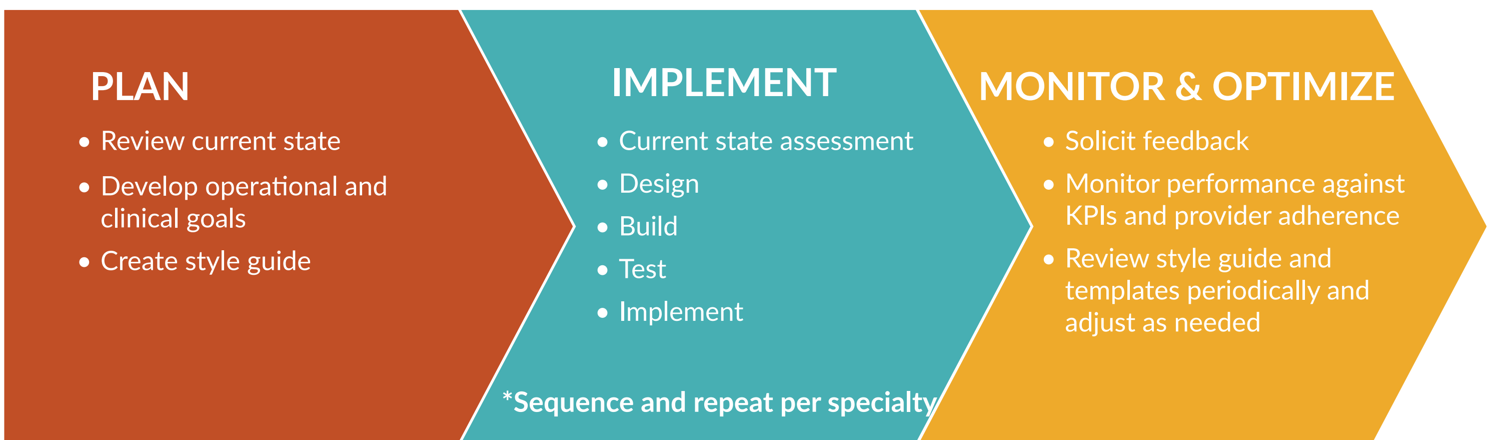


Efficient Leveraging of Technology. PDI initiatives create an opportunity for organizations that have a sub-optimally implemented EHR to redesign workflows and data capture. One of the most powerful ways to gain provider engagement and adoption is to support an initiative that simplifies their workflows, improves the presentation of information, and eases the capture of information that requires their efforts to document. Careful attention to such features as auto-population, drop-down lists, links and voice recognition can powerfully affect provider efficiency and the quality of their experience.

Pragmatic Steps to Transform the Provider Documentation Experience

The enthusiasm and optimism associated with a skillfully-facilitated, physician-led multi-disciplinary initiative can dramatically energize the medical staff and materially improve physician engagement with the organization. Substantive collaboration with business process colleagues clarifies misperceptions about documentation requirements and improves cultural as well as technical and business process domains. Likewise, the rapid pace and deep penetration of template redesign and deployment demonstrates to physicians and business leaders alike the ability of the organization to effectively execute on what had previously seemed to be an insurmountable challenge. Moreover, the improved quality and readability of the new provider documents reduce physician burnout, and enhance quality, safety, and the organization's reputation among external stakeholders who consume the medical record.

Below are pragmatic steps to advance your effort:



PLAN

Begin with a thorough assessment of the current state by interviewing clinical and business process leaders to gain an understanding of pain points, issues and ramifications of missing or incomplete documentation, such as denials or loss of revenue. Perform a limited chart review to confirm interview findings and improve understanding of current documentation practices and challenges. Gather baseline data specific to the physician experience with documentation and use the findings to create a clear and compelling case for change. Establish key performance indicators to define project success. Convene physician-led workgroups to address clinical, regulatory and quality considerations. Use the collective output to create a documentation style guide to guide specialty template development and workflow recommendations. Translate the newly-established standards into a roadmap that supports the physician leaders in working with colleagues in their individual specialties to develop documentation templates that support the standards and ease workflow. Ensure effective project and change management support is wrapped around the entire effort.

IMPLEMENT

Identify and sequence individual specialty departments to apply the style guide to their documentation templates. Physician-led workgroups that include focus on specialty-unique documentation issues and are supported by subject matter experts are more likely to be accepted for use by the providers. Ensure templates are updated with the latest workflow aids and include best practices; this effort will support organizational care models and reduce the likelihood of incomplete documentation. After the templates are built, pilot with the providers from the specialty workgroup. This pilot allows for subsequent feedback and adjustment before release to the general provider population for that discipline. Ask subject matter experts to review the notes from an auditing perspective. Build on positive feedback from the pilot group to increase the likelihood of acceptance of the new templates.

MONITOR & OPTIMIZE

Solicit feedback post go-live and monitor performance against key performance indicators and provider adherence. Conduct cycles of learning to improve subsequent rounds of template development. Review the documentation style guide regularly to ensure the standards support the clinical and business needs of the organization. Periodic evaluation of the templates also ensures the latest functionality in the EHR is utilized to enhance the documentation experience.

The provider documentation experience will undoubtedly improve as EHR vendors turn their attention to refining workflows and incorporating advanced technologies such as natural language processing and machine learning. While the future is likely bright, the present implementation of provider documentation is much less so. Now is the time to enhance patient care and provider experience by taking advantage of demonstrated best practices to make the most of the capabilities in the EHR of today as we look forward to a much better solution tomorrow.

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