Comments Regarding Meaningful Use (Stage 2)

Clinical Documentation Industry Association (CDIA)
Association for Healthcare Documentation Integrity (AHDI)

To:	**Health Information Policy Committee (HITPC)**
Attention:	**Joshua Seidman**
Deadline:	**February 25, 2011**

Clinical Documentation Industry Association (CDIA)
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Association for Healthcare Documentation Integrity (AHDI)
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- **1.2 billion clinical records are produced by the US healthcare system each year.**
- **60% of all clinical notes are documented via dictated narrative.**
- **No documentation method preserves information-rich, complex patient stories better than narrative capture.**
- **Narrative dictation is still the preferred documentation methodology by providers.**

Background

The Clinical Documentation Industry Association (CDIA) and the Association for Healthcare Documentation Integrity (AHDI) represent a sector responsible for the greater than 60% of clinical records that are documented via narrative capture (transcription and speech recognition). HITPC has requested public feedback regarding potential new EHR functionalities and proposed additions and changes to future-stage *meaningful use* definitions. To that end, CDIA and AHDI would urge this work group and all stakeholders in this process to be mindful of some critical considerations related to the **usability** of electronic health records systems and the impact that those systems can have on either improving or diminishing the quality of health information needed for truly meaningful, coordinated *care*.

Comment 1: EHR systems must be required to include a standardized interface for receiving narrative dictation.

While the current meaningful use definitions do not prohibit EMR/EHR systems from providing functionality for processing clinical narrative, the absence of a clear standard in the meaningful use definition (one that would require a narrative interface) could be misconstrued as a statement against its necessity, with the long-term impact of creating an electronic solution set that has failed to account for this critical process.

Narrative capture is still the strong preference of most physicians because they recognize that narrative entry allows them to craft an information-rich, robust summary of the care encounter that includes the important nuances of dialogue and exchange between provider and patient. It is this attention to the comprehensive patient *story* that we risk losing in the EHR if we cut providers off from the ability to incorporate narrative detail into their care summaries.

There is a growing concern among physicians that they are being forced into restricted-character fields and drop-down options that are simply not adequate for documenting a full care encounter. More alarming is the trend reported by physicians that the restrictions and requirements of EMR/EHR data

fields are dangerously reshaping the approach physicians are taking with documentation.[1] No longer is the focus on what needs to be said. Now physicians are driven by an overriding worry: *How can I say this in 1000 characters or less?* Reducing the encounter to a collection of truncated phrases is forcing physicians to abandon critical detail in favor of whatever will fit. CDIA and AHDI cannot stress more strongly that such an approach to health information management is irresponsible and dangerous. If all detail has to be pushed through the sieve of EHR-restricted fields and templates, healthcare delivery and the *patients* it serves stand to lose a great deal of vital information that will be necessary for ensuring quality of care, coordination of care, appropriate reimbursement, and legal defense.

Comment 2: The perception that narrative reports cannot be used or consumed within EHRs is a myth.

There is a prevailing presumption in the marketplace that narrative capture (ie, dictation) will no longer be feasible in the EHR due to the inability to abstract concrete data elements from its construction. *This is simply not true*. The healthcare documentation industry is powerfully innovating around this functionality. Health IT marketplace leaders are presently offering solutions for codifying clinical narrative for EHR systems through the use of natural/unique language processing.[2] These NLP technologies can codify narrative summaries with a tremendous degree of clinical specificity against a wide array of required reporting measures and standards. When deployed under the architecture of HL7 and CDA standards, these solutions allow providers the freedom to continue narrative capture, while ensuring that a meaningful codified data set can be culled from that narrative. Comprehensive detail is preserved, the EHR populated, and a *human readable* clinical summary is created – one capable of being shared with care providers and patients.

Comment 3: Preserving narrative capture is critical to redeploying physicians away from data entry and back to frontline care provision.

A great deal of emphasis has been placed on direct data entry and the benefits of real-time clinical decision support to providers engaged in the documentation of their care encounters. But very little attention is being directed at the fiscal sustainability of that model and whether or not a hybrid approach would be a more meaningful and *practical* solution. When addressing **usability**, this

[1] Ofri, Danielle MD *The Doctor vs. the Computer.* The New York Times online. 30 December 2010. 21 February 2011. http://well.blogs.nytimes.com/2010/12/30/the-doctor-vs-the-computer/

[2] Nuance/3M press release. *Nuance and 3M Team to Deliver Next Generation ICD-10-Ready Clinical Documentation Solutions.*

M*Modal website. *Technology page*. 21 February 2011. http://www.mmodal.com/technology.jsp

NLP International website. *About MedLEE™*. 21 February 2011. http://www.nlpapplications.com/about-medlee.html

work group and stakeholders must keep a critical eye on the data management burden that is shifting to the physician provider, whose expertise and skills are far more critically deployed providing care than documenting it via direct data entry. The healthcare documentation sector has capture and decision-support solutions that greatly facilitate this process in a way that meets documentation and core measures goals without compromising attention to care and treatment.

Comment 4: "Human readable" outcomes will be better achieved with clinical summaries crafted by the physician than those "assembled" by the EHR.

In reference to *Proposed MU Objectives and Measures for Stages 2 and 3* found on pages 8-10, there is significant emphasis being placed on the need for easy patient access to "relevant information" related to care encounters as well as access to clinical summaries that are to be made available in "human-readable" format. The seeming intent of these inclusions is to ensure that as healthcare pulls patients closer to real-time access to health records and treatment information, the data being accessed by patients needs to be organized and expressed in a way that can be easily understood and integrated into activities of daily living and care compliance goals.

This goal will be largely unachievable without attention to what a "narrative summary" means – beyond simple problem and medication lists assembled and spit out by the EHR. While some EMRs are equipped to assemble a summary out of discrete data elements stored in their systems, these tend to read in a stilted, cut-and-paste manner, with no connection of concepts or chronological flow. Preserving the narrative summary up front – at the point of construction by the provider – is the best way to deliver a meaningful and care-impacting clinical summary to the patient. An information-rich narrative summary that goes beyond recording critical values and captures the relational encounter between the provider and patient will have a greater likelihood of engaging patients in treatment compliance. It is also far more likely to engage patients in a constructive way toward personal health tracking and reporting.

With the clear goal of many new measures identified for stage 2 and 3 related to incorporating patient-generated health information (PHRs, for example) into EHRs, the goal cannot simply be one of swapping data between PHR and EHR. Patients have a health story that is personal and important to them, and they will be greatly dissatisfied with a health record that is stripped of all but the core data elements. Patients (and family members making care decisions for those patients) want to know that their health story has been heard, *understood*, and fully recorded. There is a large body of evidence tying positive patient outcomes to patient confidence in their care providers. As the patient becomes a participatory contributor to the health record through PHRs and post-encounter access and reporting, the meaningful detail (or lack thereof) of their health summaries will become increasingly transparent to the patient. Preserving their "story" in a satisfactory way will have to be an important consideration in this process.

Additional Specific Questions for Public Comment

On pages 14 and 15 (Section D) of the RFC, a number of new considerations and questions are provided for public comment. Those of unique connection to the healthcare documentation sector are:

1. **How can electronic progress notes be defined in order to have adequate specificity?**
2. **What are the reasonable elements that should make a care plan, clinical summary, and discharge summary?**
3. **What additional meaningful-use criteria could be applied to stimulate robust information exchange?**

CDIA and AHDI would welcome the opportunity to work with the HIT Policy Committee to specifically address these issues around the definition of common document types. This sector has rallied around the need for such definitions for nearly 3 years, with a great deal of work already accomplished in this area. Through an associate charter agreement with Health Level Seven, *The Health Story Project*[3] has developed eight technical implementation guides (IG) using HL7's Clinical Document Architecture (CDA):

- HL7 IG for CDA Release 2: Consultation Notes Draft Standard for Trial Use
- HL7 IG for CDA R2: Diagnostic Imaging Report, Release 1 Informative Standard
- **HL7 IG for CDA R2: Care Record Summary Release 2: Discharge Summary DSTU**
- HL7 IG for CDA R2: History and Physical Notes DSTU
- HL7 IG for CDA R2: Operative Note DSTU
- HL7 IG for CDA R2: Procedure Note DSTU
- **HL7 IG for CDA R2: Progress Notes**
- HL7 IG for CDA R2: Unstructured Documents

The standardization and adoption of these electronic documents unlocks the valuable data from narrative documents and will enlarge and enrich the flow of data into the electronic health record as well as speed the development of interoperable clinical document repositories for use within the enterprise and regional and national networks.

Conclusion

In December of 2010 the President's Council of Advisors on Science and Technology (PCAST) released and discussed its report entitled "Designing a Digital Future: Federally Funded Research and Development in Networking and Information Technology."[4] Per the press release of December 16, 2010:

But achieving the full potential of health information technology will require the development and adoption of a robust information-sharing infrastructure to facilitate the exchange of data among institutions, the report concludes. Unlike conventional electronic health records,

[3] The Health Story Project website. *Data Standards.* 21 February 2011. http://www.healthstory.com/standards/standards.htm

[4] The White House website. *Office of Science and Technology Policy.* 21 February 2011. http://www.whitehouse.gov/sites/default/files/microsites/ostp/pcast-nitrd-report-2010.pdf

which are effectively digital versions of paper charts that are trapped in the offices where they are created, such a system would allow health data to follow patients wherever they are, with appropriate privacy protection and patient control, while giving patients' various doctors a more complete picture of those patients' medical conditions and needs.

If it is truly the goal of electronic health record integration and adoption to improve patient outcomes and quality of care as well as reduce the cost of care for the US healthcare delivery system, the considerations outlined here will be an important part of ensuring that health *information,* and not just health *data,* is the compelling objective. Narrative capture **must** be factored into the equation for generating a meaningful health record if the goal is to create one that truly provides that "more complete picture."

For further information about the role of narrative capture in facilitating meaningful EHR adoption, please visit our association websites (www.cdiaweb.org and www.ahdionline.org).

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