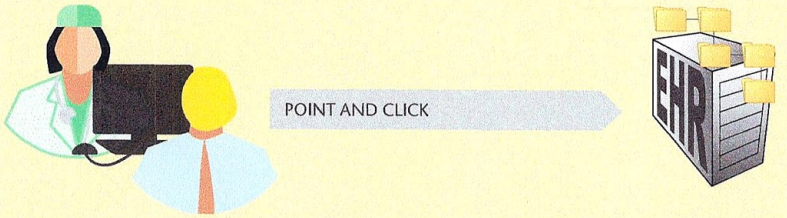
Clinical Knowledge Capture Models

Current State

Physician entering information into EMR at point of care



Findings

FAILURES: Documentation is more time-consuming, user adoption is low and the resulting records are less desirable than narrative text

Key findings of an industry survey, based on responses from 1,000 physicians, include:

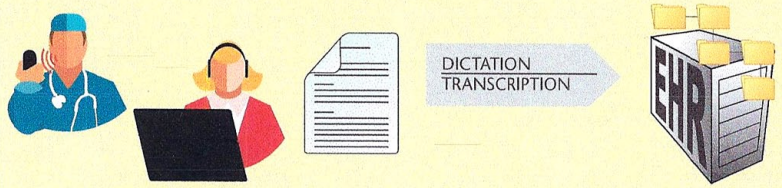
- 93% stated that the EHR did not reduce time spent documenting care
- 67% cited time associated with reliance on keyboard and mouse to document within an EHR as a major hurdle for adoption
- 97% selected narrative over structured data entry as the more valuable documentation method to treating patients
- 96% expressed concern that they may lose the patient's unique story with transition to point-and-click EHRs

There are several studies and publicly available data that point to the same observations, for example:

- According to a report published by The AC Group, a nationally-reputed Health IT consulting firm, there is a 73% failure rate of EHRs through 2007, due to usability frustrations, where failure was defined as not using EHR for 80% of their patients
- The AC group also conducted a review of 573 charts and reported that entering data into the EHR took an average of 9 times longer than using dictation to document a patient encounter

Hybrid

Physicians document patient encounters using dictation. Data generated from transcribed documents are automatically populated into the EHR as structured data



Findings

SUCCESSES: Physician productivity is maximized, physician workflow and revenue capacity is retained, and patient encounters are documented comprehensively

A hybrid approach accomplishes documentation goals without effecting physician performance

- Dictation is the most efficient means of documenting patient encounters
- Narrative documents can be reviewed quickly

Entering data into the EHR took an average of

9 times longer

than using dictation to document a patient encounter

EMDAT

DELIVERING ON THE PROMISE OF YOUR EHR