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Interprofessional Documentation: Where is Everyone?

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> **Abstract.** EHRs have become a means for interprofessional practice in healthcare. Following a rapid review, a lack of study on interprofessional documentation (IPD) was identified, especially in professions other than physicians and nurses. We proposed the definition of IPD as two or more providers documenting in an electronic system to coordinate care. Our review identified this topic needs future studies.

Keywords. Interprofessional documentation, EHRs, health informatics

1. Introduction

In a 2010 report, the WHO made a call to action to apply interprofessional practice into health systems globally [1]. Since their implementation EHRs have become a medium for interprofessional practice among providers [2]. Yet there seems to be a dearth of evaluation regarding interprofessional documentation (IPD) and to our knowledge has not been defined. The objective of this rapid review was to understand how the literature has explored IPD in EHRs.

2. Methods

The databases PubMed (n=18), CINAHL (n=14), and Google Scholar (n=26) were queried for literature. Search terms included: "interprofessional relations", "collaborative practice", "electronic health records", "notes", "notetaking", and "documentation". The Covidence software was used for screening by two members of the team. Inclusion in the final review was reliant upon the article focusing on at least two different health professions' documentation in EHRs, the literature be in English, and published after 2000. It was not required that one profession be a physician.

3. Results

The initial search yielded 58 articles; 6 duplicates were removed. After screening and full text review, 5 articles met the inclusion criteria and were included in the final review [3-7]. Table 1 shows that of the 5 articles, 4 (80%) were conducted in the United States and 1 (20%) in Japan. Except one article, all used MDs and nurses in their studies; 4 (80%) used at least one additional profession in their studies, as well as MDs and nurses.

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Of the studies, 2 (40%) were quality improvement (QI) projects; the remaining 3 (n=1, 20%) articles consisted of a Delphi panel, a questionnaire, and a descriptive correlation study.

Table 1. Study type and Professions examined, ordered by lead author.

Author(s)	Location	Publication	Study Type	Professions Studied
	Conducted	Date		
Collins et al.	United States	2011	Descriptive	Nurses, MDs, Respiratory
			Correlational Study	Therapist
Kagawa et al.	Japan	2021	Questionnaire	Nurses, MDs, Other clinical professionals
Mosher et al.	United States	2015	Quality	Nurses, MDs, Social worker,
			Improvement	Supporting Services
Sietsma et al.	United States	2021	Quality	Nurse Practitioner, MDs
			Improvement	
Thate et al.	United States	2020	Delphi Panel	Nurses, MDs

4. Conclusions

Studies were only conducted in two countries, indicating that IPD is poorly studied. MDs and nurses were the predominant professions studied, yet there are many health professions that contribute to EHR documentation. QI projects were the only repeated method used to examine IPD. Although our study is the first of its kind, additional work is needed with more databases in this area. The results indicate a paucity of literature around IPD. We propose that IPD is defined as two or more providers documenting in an electronic system to coordinate care. Future studies should focus on other health professions and their documentation in EHRs, not just MDs and nurses.

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References

- World Health Organization. Framework for action on interprofessional education and collaborative practice. WHO. 2010 Sept:1-62.
- [2] Adamson K, Maxwell J, Forbes J. Interprofessional guide to documentation in electronic health records. J. Interprof Educ & Pract. 2020 Dec;21:100387, doi: 10.1016/j.xjep.2020.100387.
- [3] Thate J, Rossetti SC, McDermott-Levy R. Moriarty H. Identifying best practices in electronic health record documentation to support interprofessional communication for the prevention of central line-associated bloodstream infections. Am J Infect Control. 2020 Feb;48(2):124-31, doi: 10.1016/j.ajic.2019.07.027.
- [4] Mosher HJ, Lose DT, Leslie R, Pennathur P, Kaboli PJ. Aligning complex processes and electronic health record templates: a quality improvement intervention on inpatient interdisciplinary rounds. BMC Health Serv Res. 2015 Jul;15:265, doi: 10.1186/s12913-015-0932-y.
- [5] Kagawa R, Tsurushima H. How the content of progress notes affects readers' perceptions of their usefulness and the burden placed on writers: improving interprofessional communication. Stud Health Technol Inform. 2022 Jun;290:168-72, doi: 10.3233/SHTI220054.
- [6] Sietsma AC, Brennan-Cook JM, Malak LT, Lauzon VL. Improving communication between hospital and outpatient psychiatric providers. Adv Emerg Nurs J. 2021 Jul-Sep;43(3):237-46, doi: 10.1097/TME.000000000000365.
- [7] Collins SA, Bakken S, Vawdrey DK, Coiera E, Currie LM. Agreement between common goals discussed and documented in the ICU. J Am Med Inform Assoc. 2011 Jan-Feb;18(1):45-50, doi: 10.1136/jamia.2010.006437.