I am Hal Baker VP and CIO of WellSpan Health, a large integrated health system with extensive EHR deployment in South Central PA. I am also the primary care physician of 253 individuals in York, PA. I want to thank the committee for allowing me to address you today. As a CIO and practicing primary care internist, I look forward to the challenges before all of us with optimism that we can make care better. At WellSpan through our EHR data, we are now able to see how we are doing as a system and as individual providers, but more importantly, we can definitively show our community that we have improved the care we provide them. Looking for the health care economy to shift from volume to value, we see a chance to thoughtfully revise how and why we document in the patient record, as well as setting clearer expectations of each other in completing this documentation

Originally the medical record was a log of the patient's condition. It was a place where caregivers wrote to each other. The demands of the fee for service coding requirements have moved the focus of progress and office notes toward getting paid at the expense of communicating. Notes are too often rich with data, but poor in useful information. For valid economic reasons EHR

documentation has unfortunately amplified this problem, often facilitating speedy creation of expansive notes that satisfy coding requirements but fail to tell the patients story. For example, the completeness of the review of systems is critical in coding, with significant payment differences between 9 and 10 systems reviewed, but I have yet to find a clinician who thoroughly reads that section in the notes of his colleagues. Most admit to never reading it at all. If it is not worth a clinician reading it, is it really worth writing? Because now only the printable individual note is the basis of each physician payment, there is often a need to import data readily available in other parts of the EHR, further cluttering the note.

As payment reform moves attention from what was done to what was accomplished, we have an opportunity to reengineer the progress and office note to support care and eliminate parts of the current documentation that don't add clinical value. As WellSpan has contemplated bundled payments, we recognize that notes will increasingly need to serve as a handoff during transitions of care. We will need a more comprehensive approach, where we focus less on taking care of diseases people have, and

more on taking care of the people who have the diseases. For analysis, some sections of the record will need to be completed as structured data for accurate reporting and to trigger decision support. For a patient with diabetes, the foot exam may need to be recorded as structured data, but the impact of the disease on her life will best be told through narrative text

By promoting online access for patients to their health information, the success of systems willing to share notes with patients will likely raise expectations for the others, making sharing notes expected. This will reduce the risk of fraud and misrepresentation. Knowing that the patient will be able to read the note after care encourages complete accuracy. In the office where I practice we have used voice recognition to complete much of the note real time by commonly dictating in front of the patient, where the patient can immediately correct any error we might make. Viewing the patient as a partner in his or her care, we have for several years printed these concurrently authored notes for the patient to take home. We ask them, "Help us make sure your record is correct." We have experienced positive results similar to the recent Open Note Project.

Through our portal, WellSpan automatically releases most lab results to the patient the morning after they are completed and imaging reports after 7 days. Despite all the theoretical worries clinicians voiced at giving patients access to their record, each time we have add transparency, it has been a non-event for providers and a patient satisfier. In my conversations at WellSpan and among industry peers, even those most hesitant to permit their patients access to information admit that they would want it for themselves. I hope you will continue pushing for patient access to health information and perhaps even encourage appropriate release of notes for compliance and engagement

Documentation accuracy and efficiency could be improved by eliminating the need to document what the systems already has time date stamped. Give providers credit for reviewing labs if they open them up during the visit. Don't make us state we reviewed the CT scan if we have scrolled through it for 60 seconds while the patient was in the office. Let EHR's passively catalogue, aggregate and present what was opened, reviewed or added during the entire episode of care, from the patient's previsit work on the portal the night before to the annotations made to the lab

results returned five days later. Then we can focus on writing notes meant to be read, not audited. Along with efficiency, we should focus on the effectiveness of documentation in ensuring high quality care. Because we trust the explicit and implicit meaning and tone of word choice, narrative text reveals what a clinician is thinking much more effectively than a quickly completed pre-populated form. It also reduces the temptation to revise the patient's story to fit the structure of the EHR. Thank you for the opportunity to share some thoughts on clinical documentation. I truly believe we can make it better for ourselves and for those we care for.