**Clinical Documentation Hearing**

**Meaningful Use and Certification and Adoption Workgroups**

**Summary and Recommendations**

Summary (may not be comprehensive):

* Clinical documentation is important and serves multiple stakeholders for primary and secondary uses. Preoccupation of billing uses may impede clinical use of the documentation.
* Due to the time and effort required to record unstructured data, productivity tools have been developed (including, templates, cut/paste, copy forward, macros, etc.). Overuse or inappropriate use of these productivity tools has resulted in a concern about accuracy of the documentation.
* Little quantitative, available evidence on accuracy of documentation or how to assess for good documentation
* Anecdotes about poor documentation
* No clear method associated with high quality documentation => don't prescribe just one method or prevent other methods
* Quality of note not necessarily associated with Q of care (except templates with specialists)
* NLP may be useful to get structured concepts out of free text
* VR efficient, but not work for everyone
* Hybrid of VR + NLP + GL-directed structured text may be good compromise
* Sharing notes with patient may help improve quality and accuracy of notes => decrease fraud
* Very hard to capture medical record in a dynamic EHR; it's hard to reducer to paper printout
* Some excessive or inappropriate documentation is due to misunderstanding of E&M coding criteria

Draft Recommendations (may not be comprehensive):

1. Do not prescribe or prohibit method of clinical documentation. Guide appropriate use through education and policies
2. Help reader assess accuracy and find relevant changes by making the originating source of sections of clinical documents transparent. Analogous to "track changes" in Word
	1. Default view of documents in the medical record and those transmitted to other EHRs is a "clean copy" (i.e. not showing tracked changes). The reader can easily click a button and view the tracked-changes version.
3. To improve accuracy, to improve patient engagement, and to guard against fraud, EHRs should have the functionality to share progress notes with patients
4. Further innovation required to display meaningful information (possibly using graphical views), rather than just lots of text
5. Increase education about E&M coding criteria; better yet, as payment reform emphasizes outcome over transactions, seek to eliminate E&M coding criteria