Clinical Documentation Hearing Recommendations Meaningful Use and Certification and Adoption Workgroups

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Clinical Documentation Hearing

- The Future State of Clinical Data Capture and Documentation, AMIA
- Role of Clinical Documentation for Clinicians
- Role of Clinical Documentation for Care Coordination across the Health Team
- Role of Clinical Documentation for Secondary Uses
- Role of Clinical Documentation for Legal Purposes

Hearing Summary (I)

- Clinical documentation serves multiple stakeholders for primary and secondary uses.
- Preoccupation of billing uses may interfere with clinical use of the documentation. Legal requirements ("if it is not documented, it did not happen") also drive documentation behaviors
- Productivity tools 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 and has made it difficult to find the important information
- 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

Hearing Summary (II)

- Quality of note not necessarily associated with quality of care
- Voice recognition is efficient, but does not work for everyone
- Natural language processing may be useful to get structured concepts out of free text
- In order to balance the richness contained in free text with the value of coded information, may need to use hybrid of both text and structure. Voice recognition + natural language processing + guideline-based structured templates may be used
- Sharing notes with patients for viewing may help improve accuracy of notes => decrease fraud
- Very hard to capture medical record in a dynamic EHR; cannot reduce to paper printout
- Some excessive or inappropriate documentation is due to misunderstanding of E&M coding criteria
- Ensure that vendors have security provisions that comply with requirements of "legal medical record" (e.g., data integrity, data provenance)

Recommendations (I)

1. Move clinical documentation menu item to core in stage 3
2. Do not prescribe or prohibit method of clinical documentation. Guide appropriate use through education and policies
3. Help reader assess accuracy and find relevant changes by making the originating source of sections of clinical documents transparent. Analogous to "track changes" in MS Word™
    - 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.

Recommendations (II)

4. To improve accuracy, to improve patient engagement, and to guard against fraud, EHRs should have the functionality to provide progress notes as part of MU objective for View, Download, and Transmit
5. Further innovation and research required to collect and meaningfully display information (possibly using graphical views), rather than just text
6. Increase education about E&M coding criteria; better yet, as payment reform emphasizes outcome over transactions, seek to change E&M coding criteria to reduce over- reliance on specific language in clinical documentation
7. Propose that HITSC review what standards are needed to ensure that CEHRT maintains legal medical record content for disclosure purposes (e.g. what was accessed during the encounter and what gets printed out as the legal medical record?)

Discussion