Excerpted from ACP Policy Compendium

CLINICAL DOCUMENTATION IN THE 21ST CENTURY

Policy Recommendations for Clinical Documentation

Position 1: The primary purpose of clinical documentation should be to support patient care and improve clinical outcomes through enhanced communication.

Position 2: Physicians working with their care delivery organizations, medical societies, and others, should define professional standards regarding clinical documentation practices (4) throughout their organizations. Further, clinical usefulness of health information exchange (HIE) will be facilitated by appropriate re-design of clinical documentation based on consensus-driven professional standards unique to individual specialties as a result of collaboration with standards setting organizations.

   A. The clinical record should include the patient's story in as much detail as is required to retell the story.

   B. When used appropriately, macros and templates may be valuable in improving the completeness and efficiency of documentation, particularly where that documentation is primarily limited to standardized terminology, such as the Review of Systems and Physical Exam findings

   C. The EHR should facilitate thoughtful review of previously documented clinical information. Ready review of prior relevant information, such as longitudinal history and care plans, as well as prior physical exam findings may be valuable in improving the completeness of documentation, as well as establishing context.

   D. . Where previously documented clinical information is still accurate and adds to the value of current documentation, this process of "review/edit and/or attest, and then copy/forward" (hereafter referred to as copy/forward) of specific prior history or findings may improve the accuracy, completeness, and efficiency of documentation. However these documentation techniques can also be misused – to the detriment of accuracy, high quality care, and patient safety.

   E. Effective and ongoing EHR documentation training of clinical personnel should be an ongoing process.

Position 3: As value-based care and accountable care models grow, the primary purpose of the EHR should remain the facilitation of seamless patient care to improve outcomes while contributing to data collection that supports necessary analyses.

Position 4: Structured data should be captured only where they are useful in care delivery, or essential for quality assessment or reporting.

Position 5: Prior authorizations, as well as all other documents required by other entities must no longer be unique in their data content and format requirements.

Position 6: Patient access to progress notes, as well as the rest of their medical records may offer a way to improve both patient engagement and quality of care.

Position 7: The College calls for further research to:
   A. Identify best practices for systems and clinicians to improve accuracy of information recorded and the value of information presented to other users.
   B. Study the authoring process and encourage the development of automated tools that enhance documentation quality without facilitating improper behaviors.
   C. Understand the best way to improve medical education to prepare new and practicing clinicians for the growing uses of health information technology in the care of patients and populations and to recognize the importance of their responsibility to document their observations completely, concisely, accurately, and in a way that support their reuse.
   D. Determine the most effective methods of disseminating professional standards of clinical documentation and best practices.

Policy Recommendations for EHR System Design to Support 21st Century Clinical Documentation

Position 1: EHR developers need to optimize EHR systems to facilitate longitudinal care delivery, as well as care that involves teams of clinicians.

Position 2: Clinical documentation in EHR systems must support clinicians' cognitive processes during the documentation process.

Position 3: EHRs must support "write once – reuse many times" and embed tags to identify the original source of information when used subsequent to its first creation.

Position 4: Wherever possible, EHR systems should not require users to check a box or otherwise indicate that an observation has been made or an action has been taken if the data documented in the patient record already substantiate the action(s).

Position 5: EHR systems must facilitate the integration of patient generated data, and must maintain the identity of the source.