

STATE OF THE NOTE SUMMIT 2021

FIVE RECOMMENDATIONS FOR EHR VENDORS

The goal of our summit was related to the content of clinical documentation, not the tools needed to create it. However, there were several concepts that all of our attendees hit upon for improving EHRs in relation to clinical documentation. We encourage EHR vendors to explore these with their users.

Allow notes to be written in SOAP, and reviewed in APSO, automatically

SOAP is widely agreed as the best way to write a note, but can be tedious to review. APSO puts the right information first for review, but is more difficult to write. Allowing the system to sort these based on the users need was seen as a clear improvement.

Allow for combining Patient Instructions and A&P

The assessment and plan of a patient's condition often include clear steps for what should happen next. Frequently these are repeated in a separate section for patient instructions that will be given to patients. As most notes will now be shared directly with patients, allowing them to be combined is a win for efficiency. A robust solution will allow for combining, while still highlighting what is most relevant to a patient.

Automate expansion of abbreviations for patient facing documents

Medical abbreviations can be confusing for patients, and create a higher bar for health literacy. A software solution for allowing physicians to quickly enter documentation with abbreviations that will be reformatted to standard language when seen by a patient would help.

Allow linking out to data that is elsewhere in the EMR

A key element in note bloat is the need to reference specific data sets that were referred to as part of medical decision making. Allowing for note readers to easily 'jump' to the relevant data within the EMR would reduce the need for lengthy notes that are full of duplicative data.

Allow for simple, granular, inclusion of discrete exam data

Physical examinations, review of systems and other assessments can involve large amounts of discrete data and including all of those items can create a wall of text that obscures useful insights. Allowing clinicians to easily summarize, or include only 'relevant' items to this visit, would add value and clarity for this information in a note.