Guidelines presented for clinical documentation in 21st century

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(HealthDay)—Guidelines have been developed for clinical documentation and interrelated issues. The position paper has been published online Jan. 13 in the *Annals of Internal Medicine*.

Thomson Kuhn, from the American College of Physicians in Washington, D.C., and colleagues developed a policy paper to address issues relating to health information technology and informatics in U.S. health care. To improve the quality and value of clinical documentation, the authors developed recommendations for clinicians, provider institutions, technology vendors, government regulators, payers, and other interested groups.

The researchers note that the primary goal of electronic health record (EHR)-generated documentation should be concise-, history-rich notes that reflect the information collected and are used to formulate a diagnostic/treatment plan and recommended follow-up. Clinical documentation should support patient care and improve clinical outcomes via improved communication. The clinical record should include the patient's history in as much detail as is required. The primary purpose of the EHR should remain the facilitation of seamless patient care to improve outcomes, even as value-based care and accountable care models grow. Structured data should only be captured where they are useful in care delivery or quality assessment. Improvements in patient engagement and quality of care may result from patient access to their medical records.

"We must work together to fundamentally change the EHR from a passive recipient of information to an active virtual care team member," the authors write.

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