

EHR Clinic Notes Need Redesign



Electronic health record documentation tools, including the clinic note that recaps a patient's medical history, should be redesigned to better meet the needs of physicians, according to a new study published in the *Journal of the American Board of Family Medicine*.

Researchers from the University of Missouri noted that EHR documentation "mimicked" the paper records which were difficult to navigate due to increasing federal and regulatory demands on required information. As a result, EHRs include a lot of redundant and cluttered information presented in an outdated fashion.

"While EHRs have granted physicians access to more information than ever before, they also include lots of extraneous information that does not contribute to the care of the patient," says Richelle J. Koopman, MD, associate professor of family and community medicine at the MU School of Medicine. She recommends patient information become more organized to allow physicians to spend more time with their patients instead of scrambling through notes to find the most valuable information.

In this study, Dr. Koopman and colleagues observed primary care physicians using EHRs in preparation for patient visits and asked them to highlight which parts of the clinic note they found most and least important. Based on the results, the majority of physicians found the "assessment" and "plan" sections of clinic notes to be the most important, while the "review of systems" section — which is required by Medicare and Medicaid for billing purposes — was deemed the least valuable.

"Most physicians we observed skipped right to the assessment and plan sections, which include the diagnoses of the patient from the last visit and notes on how physicians planned to address the diagnoses," Dr. Koopman points out. "In addition, physicians expressed a lot of frustration about the poor utility of the 'review of systems' section and said it had little value in addressing patient care."

She says this study supports changes to the information needed for medical billing with a more streamlined way of presenting medical information that can ultimately reduce medical errors.

Numerous leading-edge tools that will facilitate the changes Dr. Koopman's research highlighted will be implemented at MU Health Care this year, according to Thomas Selva, MD, chief medical information officer for MU Health Care.

Dr. Koopman will conduct further research to discover the best way to organize patient information in clinical notes by using eye-tracking software to see how quickly physicians can find information using different clinical note prototypes created by her team.

Source: [University of Missouri Health](#)

Image credit: MU Health/Justin Kelley

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