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Electronic documentation guidance aims to prioritize values, reduce burden

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Much has changed in the way pediatricians document care, including the transition to electronic health records (EHRs) and the changing stakeholders, policies and regulations regarding clinical documentation. For many, these shifts have altered the content, structure and even the perceived purpose of clinical documentation.

While electronic documentation has improved information availability and legibility, new problems have been introduced, including documentation burden, "note bloat" and information overload. These issues have necessitated reexamining documentation priorities and requirements.

Pediatrics is a unique specialty in many ways, involving both patients and their families. Additional stakeholders in clinical documentation include schools, as teachers and school nurses serve as important caregivers for children and adolescents. In some states, teens have the right to consent to their own care in certain situations and might want to keep that information confidential from parents or guardians.

Thus, a new AAP policy statement and technical report provide guidance that aims to drive electronic documentation improvement initiatives. The goal is to maximize the benefits of electronic documentation and functionalities while mitigating their potential negative aspects.

The documents, *Electronic Documentation in Pediatrics: The Rationale and Functionality Requirements*from the AAP Council on Clinical Information Technology, are available at https://doi.org/10.1542/peds.2020-1682 (policy) and https://doi.org/10.1542/peds.2020-1684 (technical report) and will be published in the July issue of *Pediatrics*.

The policy includes the following recommendations.

Electronic documentation and documentation functionality should support pediatric core values, including age-based, longitudinal, preventive and patient- and family-centered care.

Documentation'sprimary role is to communicate the patient's clinical picture effectively. Electronic functionality should enhance clinicians' ability to document and review information in a way that clearly promotes the values of pediatric care.

For example, documentation and review of documentation should support a *longitudinal*view of the lives and care of patients in multiple areas such as growth, immunizations, developmental milestone attainment,

academic and life skill achievement and the course of chronic medical or social conditions — even if the patient falls outside norms in any of these areas.

Similarly, electronic documentation tools should reflect that pediatric care, including measurement, screening and anticipatory guidance, needs to be age-based and may need to be adjusted for infants born prematurely or patients with other conditions.

Documentation burden needs to be reduced. Documentation functionalities and strategies that focus on pediatric core values could help eliminate redundancy and reduce documentation burden.

The nation has begun to recognize and strategize about how to reduce documentation burden and physician burnout. A focus on pediatric core values in documentation may help in this regard. For example, as part of patient- and family-centered care, pediatricians work to understand and support the family unit. Functionality that allows shared family and social documentation across multiple family members could eliminate the need for separate documentation for each family member and lead to a more complete and accurate family record.

In addition, the integration of patient/family-generated information into clinical documentation may highlight patients' and families' input in their care and reduce the need for the clinical staff to add this documentation themselves. Another example is work to streamline documentation shared with schools, which could improve communication, reduce documentation burden for pediatricians and reduce the risk of medical errors.

The hope is that recommendations in the policy statement and information in the technical report will provide a framework for documentation improvement, including the introduction of new technologies. While recognizing that other stakeholders such as medical billing, regulatory reporting and research will continue to use clinical documentation, improvement should focus on meeting these needs in a way that minimizes the clinical narrative and documentation requirements of the clinical staff.

To ensure that pediatric core values are upheld, pediatricians — and clinical informaticists, if possible, who can help bridge the gap of understanding between frontline clinicians and EHR professionals and vendors — are critical participants in any documentation improvement project.

Dr. O'Donnell, a lead author of the policy statement and technical report, is a member of the AAP Council on Clinical Information Technology Executive Committee.

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