# 10 THINGS ABOUT:
# EHRs – DOCUMENTATION

1. No matter how good the system, what you get out of it will only be as good as what you put in. In other words, garbage in, garbage out. If you have not been thorough with your documentation in the past, your EHR system might make your record look "prettier" but it will not in and of itself create a record that supports good patient care and would be useful in your defense in the event of a claim or a lawsuit.

2. Concerns about patient safety and the use of electronic health records have been in the news for years. As the use of this technology has grown so have these concerns. In 2015 ECRI Institute listed errors associated with EHR use among its Top 10 Patient Safety Concerns and the Joint Commission issued a Sentinel Event Alert on the Safe Use of Health Information Technology.

3. A written record often contains seemingly extraneous information that can become extremely important to a physician's defense. For example, who was present when a patient was informed of the risks associated with a certain medication and what questions were asked and answered, or what comments the patient made regarding her adherence to treatment. Unfortunately, some EHR systems don't provide a mechanism for users to include this information and instead they are limited to checking boxes. The absence of the ability to write a complete narrative is a frustration many physicians report with EHR use.

4. Template use is an area that is undergoing scrutiny by CMS and other payors. Templates are used to easily provide additional detail to a note but may not accurately reflect treatment – for example, they may misstate a patient's age or gender. The result is often a record filled with a large number of identical notes which call into question whether the physician truly did a thorough evaluation of the patient at each encounter. If a template is used for informed consent, it may not capture all of the information you need to establish that the informed consent discussion actually took place, e.g., who was present.

5. Some systems will automatically populate entries with information from previous visits. On occasion the system will erroneously enter information from the previous patient. It is often impossible to determine whether data was entered by a clinician or by the system itself. Relying on default data can cause you to make false assumptions about a patient's condition and making inaccurate default data a part of your record will cause you to lose credibility in any subsequent litigation. Further, some state medical boards have written position statements cautioning licensees against relying upon software that pre-populates fields.

6. As with template use, the function which allows a provider to copy and paste portions of previous entries into a new note is undergoing scrutiny by CMS. While intended to improve the thoroughness and ease of documentation, this function may be misused leading to problems both for the physician and the patient. Risks include: the possible perpetuation of erroneous information leading to incorrect diagnosis/treatment;

the potential for copying and pasting the note to the wrong treatment date or even the wrong patient's record; the inability to identify the author of the original note and the date of that note; and duplication of information not relevant to the current encounter.

7. If you choose to use documentation shortcuts such as templates and the copy/paste function you must remember that it is you who will be responsible for insuring that the encounter is billed using the appropriate code. Though the system may create documentation that meets the coding requirements for the highest code, it does not mean that you should bill at that code. Medical necessity is the key to accurate coding – even if a coding tool suggests a higher level of service.

8. EHR users sometimes find that so much information is being captured and stored that they cannot find relevant information. This can be problematic in emergency situations as well as routine treatment. One practical solution to this dilemma is to periodically print out a patient record and evaluate it for adequacy. A good medical record is one in which a subsequent provider or an expert witness would be able to understand what happened during the treatment relationship and why.

9. Metadata is literally data about data and provides an audit trail of everything that occurs within the electronic record. What this means is that every time you sign onto an electronic health record system, you leave a trail of your activity including what patient records and what portions of those records were viewed, the actual time the record was viewed, how much time was spent looking at the record (including how long it took to view and override a safety alert or other clinical support tool), what entries were made, and any changes that were made to the record. And, as with all other parts of the medical record, metadata may be discoverable in a medical malpractice lawsuit.

10. Clinical decisions support systems are designed to assist physicians by making recommendations about possible diagnoses from a set of signs and symptoms, provide alerts on possible drug interactions or critical lab values, or to question a physician's medication dosage or other orders. Unfortunately, these systems often produce a large number of alerts, many of which are not relevant. In other instances, the alerts may be based on out-of-date information. While it is true that many alerts are not clinically relevant it is also true that there are some that are and therein lies the problem. Physicians can become so accustomed to seeing alerts that are not relevant that they tend to not notice when an alert is relevant which is known as alert fatigue.

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