Potential Risks and Pitfalls of EHR Systems - Part I

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Electronic communication has revolutionized the care provided within healthcare. The ability to exchange healthcare information electronically and the utilization of electronic health records gives providers the opportunity to provide higher quality and safer care for patients while creating measureable benefits for the organization. Through the use of electronic communications, providers gain opportunities to better manage care for their patients and provide better healthcare by having accurate and complete information about patients available at the point of care. It also enables safer, more reliable prescribing, easier and more accurate diagnosis of patients, promotes complete and legible documentation and allows streamlined coding and billing. Unfortunately, the technology intended to make professional lives easier and provide better patient care is creating new and additional risks for the healthcare provider. This article is a brief overview of some of the most common pitfalls that create potential liability for the practitioner.

To begin, it would be impossible to overemphasize the importance of maintaining complete and accurate medical records regardless of the format. Whether in electronic form or paper chart, the medical record WILL BE the most important piece of physical evidence in a malpractice trial. Therefore, completeness and accuracy are of utmost importance.

One of the primary causes of erroneous records is “digital assists.” Every EHR system utilizes digital assists, short cuts designed to improve efficiency and save time. When used properly, they serve their intended purpose. However, if used improperly, the result is a medical record that is inaccurate, incomplete, and unreliable, containing duplicitous carryover information that is often outdated. Although they are known by many names, some of the most popular digital assists/shortcuts are: “templates,” “copy and paste,” “auto-population,” and “cloned notes.”

In some systems, a template may be created based on checking a list of systems. As the patient visit progresses, it may become apparent that the template selected may not be the correct one. In those cases, the provider must make necessary changes to ensure the visit note accurately reflects both the care provided and the practitioner’s thought processes. Although it can be helpful to have a template to use as a starting point for documentation of

a patient visit, it can easily lead to over-documentation. Hurriedly clicking checkboxes and failing to deselect boxes can inadvertently result in a two- to three-page office note that includes systems that were not assessed or care that was not provided. This over-documentation can increase liability exposure if it does not accurately reflect what took place.

Similarly, the use of templates or click boxes can create an inaccurate clinical picture, potentially failing to accurately describe the complexity of the patient's condition because of the limitations created within the template itself. Because a template can prompt review of certain systems, or guide the assessment to seek specific findings, some providers may be misled to look for only those findings or diagnoses. As a result, a template can create tunnel vision that makes it easy for the provider to overlook other significant clinical findings, resulting in a delay in diagnosis or treatment of the actual problem.

The copy-and-paste function creates the capability to produce an office note by using a previously documented assessment. While there may be clinical reasons for a practitioner to review the notes from the patient's last visit to determine whether or not symptoms have resolved or worsened, the use of a "copy and paste" capability to create the new note from the old note is fraught with potential problems.
Copying information from a prior note and pasting into a new note can result in notes which are identical for multiple office visits. This is particularly risky for a physical examination where the patient's conditions may have changed since the prior visit and the record does not accurately reflect the complexity of the patient's condition.

Copying and pasting may result in irrelevant over-documentation perpetuating outdated or incorrect information and producing voluminous progress notes that obscure important new information. Copying and pasting entire x-ray reports or lab data into notes only adds to the problem. This practice can further result in entries with errors that are repeated in multiple office notes, becoming 'immortalized'. This is particularly apparent when typographical errors and non-standard abbreviations first used in the initial entry are carried over into subsequent notes. "Auto population", like templates, allows the EHR system to pre-fill information in specific areas of the medical record as a means of creating a short cut or improving the efficiency of the documentation process.

Most EHR systems contain check boxes for the practitioner to use to select symptoms and findings that reflect the patient's condition. These check boxes often are connected to templates. When a template is selected, certain fields in the EHR are automatically filled with the "canned" or pre-selected text. This text can be diagnosis-specific and the checkboxes may be pre-selected based upon the template selected. These auto-populated fields can include both normal and abnormal findings. The physician must make a note to know what information is auto populated so that he or she can review those observations

and edit as needed.

Another type of auto population in EHRs occurs when certain fields in the patient's medical record are completed with information from data fields in a previous office visit. This may occur through auto population of the office visit note itself or in specific sections of the record, such as the medical or surgical history.

In order to avoid compromising the integrity of the entire medical record, the provider should be aware of those areas of the medical record that are auto populated and carefully review the office visit notes An inaccurate record may lead to errors in the decision-making process, resulting in an ineffective treatment plan that will be difficult to defend in a court of law. It is very difficult to explain conflicting entries to a jury. When the chief complaint in review of systems is not consistent with the exam and assessment, it appears to be sloppy and the entire medical record is called into question. Some EHRs will not allow editing or correction of entry errors made in progress notes.

While the error may persist in several locations in the EHR, which cannot be edited, upon discovery, it is nevertheless important to create an addendum to correct the error. It should be clearly identified as an addendum with the reason(s) for correcting the error stated. To avoid the appearance of being self-serving, an addendum should not be written after an adverse event and certainly not after a claim has been filed or asserted without first speaking to a Claim Attorney.

Patients and juries alike want to see individualized care. A major problem with digital assists/shortcuts is that, when used incorrectly, they give the appearance of "cookie cutter" medicine and show a lack of attention to the patient. The best way to overcome this in an EHR is by using the patient's own words wherever possible in the documentation. If a patient describes her pain as feeling as if someone stuck an icepick in her, document that in the narrative portion of the EHR in quotation marks as patient described pain as, "feeling as if someone stuck an icepick in her".

The timeliness of the documentation is critical in order to ensure that the information is accurate, complete, and does not appear suspect. Office notes and procedure notes should be completed, reviewed, and signed within twenty-four to forty-eight hours. If the notes are not completed contemporaneously, any intervening event between when the patient was seen and the documentation was completed can make the documentation appear self-serving.

From a billing perspective, keep in mind that notes must be completed and signed prior to submission for payment. A problem that often arises with billing is cloned notes. Cloned

notes may have entries worded exactly like previous entries, may lack specific individual information, and may give the appearance that every patient visit details the exact same problem, symptoms, and requires the exact same treatment. If notes are audited by CMS or a private payer and appear to be cloned, this may raise red flags about whether the actual care was provided to support the level of coding billed.

If notes are left in an unlocked state in the EHR, potential risk exists because staff or subsequent providers may unintentionally modify the notes. This could affect patient safety due to future treatment decisions based on the incomplete or altered information. Moreover, in the event of a lawsuit, modifications made after the initial visit note may appear inconsistent, self-serving, and create other hurdles with defensibility. In addition, submission of billing prior to the signature and locking of notes may appear fraudulent.

The adoption of a new EHR system almost always requires changes in office/hospital processes and work flows. Couple this with the fact that not all physicians and staff are comfortable with the use of the EHR system, (or that they are required to use different EHR systems at different locations - hospital vs. office, for example) and it may lead to the creation of work-arounds to accomplish the same level of productivity that was achieved prior to the adoption of the EHR system. Unfortunately, these work-arounds may not reflect the “complete picture” and may lead to inconsistent processes, which can be very confusing and frustrating.

Training and consistency is the key to avoiding systems errors. When staff covers for other staff, if not properly trained, they will have varying differences for the same processes that may lead to ineffective tracking, patient notification of test results, and/or follow-up. This could have an end result of a devastating medical error or delay in medical diagnosis. It is important that everyone on the team be trained and familiar with the EHR system and they all use it in a consistent manner.

Avoiding the pitfalls of inconsistent processes can only be accomplished with a practice-wide focus on the creation of standard processes for use with the EHR. If an EHR system is not meeting the provider’s needs, a provider can work with the vendor rather than allowing staff to create individual work-arounds.

Utilization of an EHR can promote patient safety, improve accessibility of information and enhance continuity of care. However, the adoption of any new technology can have unintended consequences. Having an awareness of the potential pitfalls is the first step to ensuring notes are an accurate representation of the patient findings and treatment provided. In part two, to be published in the April 2019 edition of The Sentinel, we will examine audit trails and laws surrounding EHRs.

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