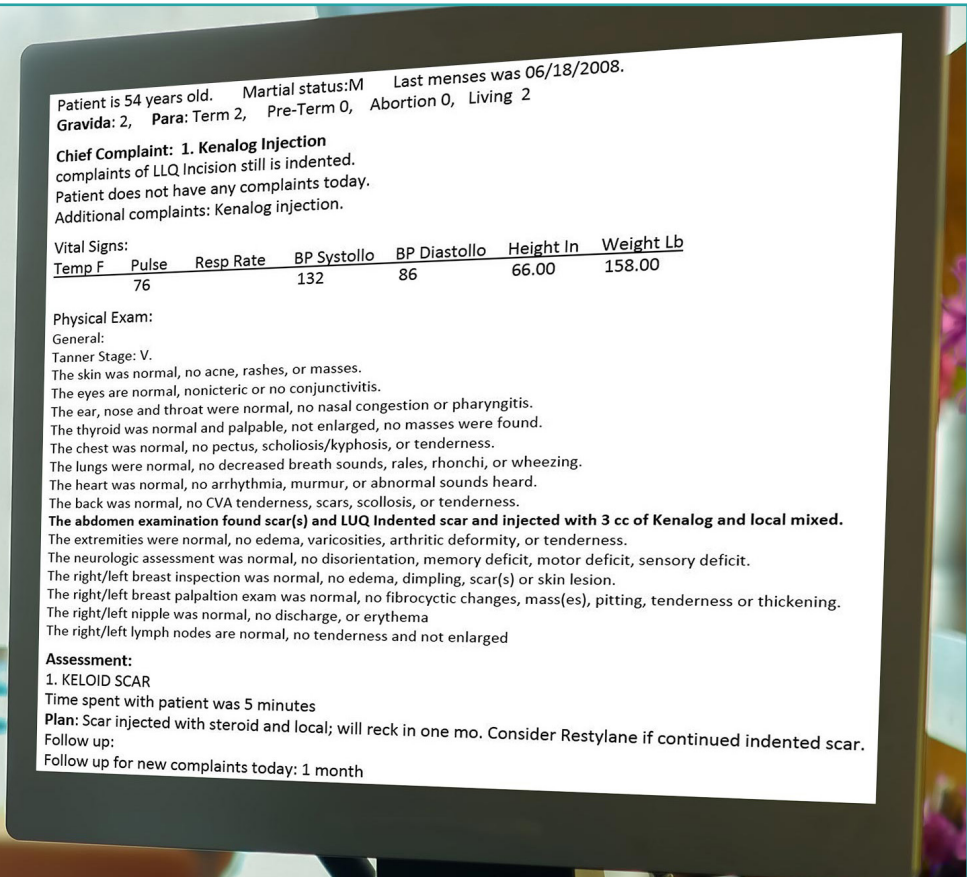


WHAT'S WRONG WITH THIS EHR NOTE?



Answer:

The note says “time spent with patient was 5 minutes,” and yet during this brief time, a complete examination—including Tanner staging (of a 54-year-old), breast examination, node examination and neurologic examination—was done and documented.

Learning points:

This is a poster child for a templated EHR note and COPIC sees many degrees of this issue. Similarly, “copy and paste” functions can lead to voluminous documentation of evaluations/examinations that were never done. Additional observations include:

1. Billing and coding can be based on the documentation of an encounter. Payers may be quick to deny payment when it is apparent that the documentation is untrue. Furthermore, systems may be subject to extrapolation of such denials of payments

2. When adverse outcomes do arise, one’s credibility may be seriously undermined with such notes.
3. The true cost of inaccurate and “word salad” documentation is that the signal gets lost in the noise. How does one determine what the important finding is or the important differential diagnosis, when that information is buried in lines of text?

What to do?

Despite the concerns that this issue is “everywhere, or everyone does it,” clinicians and the organizations they work in would be wise to develop policies of appropriate use of copy and paste and templates as time-saving functions. This may include consequences for noncompliance if we want to move toward more accurate and useful clinical records.

