CORE CDI

The Electronic Health Record- A Two Edged- Sword

The adoption of the electronic health record is widespread with 90% of hospitals and health systems and upwards of 80% of physician office practices utilizing the computerized record. Tangible material benefits abound with the use of the EHR including legibility, enhanced security although this has not obviously materialized with all the security breaches, enhanced access and availability and promotion and achievement of time saving documentation capabilities. The notion of time savings for physicians in documentation associated with the EHR must be called into question when various observational studies including one published in a 2017 Annals of Family Medicine journal highlighting the fact that each weekday, physicians spent an average of 5.9 hours out of an 11.4-hour workday working in the EHR. According to the article that consisted of 4.5 hours during clinic times and 1.4 hours after work. Clerical and administrative tasks such as documentation, order entry, billing and coding and system security, accounted for 44 percent of the total EHR usage time. About one-third of the time was spent on medical care EHR tasks such as chart reviews and problem lists, while inbox management took up 24 percent of family physicians' time. (Annals of Family Medicine-Tethered to the EHR) Obviously, physician face-to-face time with the patient is significantly curtailed with potential quality of care suffering given time is a precious physician commodity.

When a Benefit is Not a Benefit….

A major benefit of electronic health records, yet often not publicized but deeply ingrained in physician's documentation practices, is the functionality of cut and paste and care forwards. These practices are epidemic, in many ways out of control and create significant problems and concerns that physicians often are not aware of or choose to ignore and overlook. The practice of cut and paste, cloning of notes and carry forward may be defined in numerous ways with the following serving as a reasonable representation for discussion purposes in this article, appearing in the Toolkit for the Safe Use of Copy and Paste article by the Partnership for Healthcare IT Patient Safety:

- Cut and Paste- Removing or deleting the original source text or data to place it in another location
- Copy and Paste- Action performed either by keyboard command (e.g., Ctrl + C to copy and Ctrl + V to paste) or with a mouse; selecting data from an original or previous source to reproduce in another location
- Cloning- Duplication of a note

- Whole Note Cloning-Copying patient notes from one visit to the next; copying a note from one patient encounter to the next with little or no editing.

Physicians utilize the cut and paste and carry forward functionalities of the electronic health record as a time saving measure, countering the myriad number of competing forces in healthcare and the doctoring of medicine. In many recent conversations with physicians who I observed regularly utilizing the cut and paste and carry forward functionalities of the electronic health record, it is clear of the physician lack of understanding and appreciation for the real dangers of cut and paste and carry forward practices epidemic in nature. The Joint Commission has summarized the inherent risks of copy and paste in a February 2015 Quick Safety Preventing Copy and Paste Errors in the EHR publication (Joint Commission-Preventing Copy & Paste Errors in EHR):

- Copying and pasting inaccurate or outdated information
- Redundant information in the EHR, which makes it difficult to identify the current information
- Inability to identify the author or intent of the documentation
- Inability to identify when the documentation was first created
- Propagation of false information
- Internally inconsistent progress notes
- Unnecessarily lengthy progress notes

The Real Indisputable Dangers of Cut & Paste

The potential for degradation in quality patient care is real with indiscriminate use of cut and paste and carry forwards. Take a close look at the Doctor's Company recently released article titled Electronic Health Record Closed Claims Study: Navigating the Rising Risks of EHRs, an excellent discussion of the inbuilt risks of the EHR. (EHR Article-Doctors Company) The following quote drives home this very point:

"This study is an eye-opening report for doctors on the importance of having processes in place for back-up, cross-checking, and auditing the documentation in their EHRs."

Aside from patient safety, cut and paste provides for other distinct patient risks as pointed out in this highly resource rich content that is a must read for all involved in clinical documentation, regardless of whether you are involved in direct patient care. Malpractice cases are brought predicated on alleged or real concerns for potential quality of care and outcomes issues. The Doctors Company found in their most recent study of 66 HER-related claims from July 2014 through December 2016 that **50 percent** of these claims were caused by system factors such as failure of drug or clinical decision support alerts and **58 percent** of claims were caused by user factors such as copying and pasting progress notes. Fifty-eight percent of claims attributable to copy and paste progress notes should be a wake-up call for physicians to pay attention and become more vested in adhering to patient focused quality documentation practices that drive good patient care while reducing the risk of untoward patient outcomes and avoidable malpractice exposure. By the way the article contains two short video clips outlining the perils of cut and paste practices, a must review and resource CDI specialists can capitalize upon in making a

compelling case for physicians and other clinicians to use of the cut and paste functionality appropriately and discriminately.

Clinical Documentation Improvement Specialists- Driving Change in Documentation Integrity

Clinical documentation improvement specialists both collectively and individually play a vitally significant role in addressing the widespread inappropriate use of the cut and paste functionality promoted and facilitated by the electronic health record. Visibly noticeable in discussion with fellow coders, clinical documentation improvement specialists, quality and safety professionals to name just a few is the frustration with rampant cut and paste in the record. Complaints associated with this poor practice of documentation abound, yet there seems to be little action and concerted effort to address in a meaningfully positive way. CDI is at the forefront to address this ongoing challenge of documentation through their role as patient and physician advocates for improvement in the quality and completeness of documentation. Devote our energies actively as opposed to passively in addressing inappropriate and misdirected use of the cut and paste practice of clinical documentation, working collaboratively with physicians to promote and achieve documentation excellence putting patient welfare at the center of our discussion. After all, patient care and the welfare of the patient are the hallmark of physicians and their practice of medicine, devoting at least twelve years of their life in the long road to earning the designation of a physician.

Start a movement at your facilities to at least begin a discussion that interests clinicians and medical staff leadership to start the process of dealing with and addressing the dangers and perils of cut and paste functionality of the electronic health record. Do not be reluctant to confront physicians who blatantly misuse the cut and paste documentation and outline the well-known dangers to the patient if the note provides outdated potentially inaccurate information. Recently, I confronted a physician in a collegial manner who cut and paste his entire last progress note into the discharge summary, obviously not performing the discharge summary yet billing for the work performed through the discharge management E & M code assigned. This is certainly not a sound practice all around, not the least impacting facilitation of sound post-acute care that decreases the likelihood of penalty laden reimbursement. Strive to raise the awareness of facility specific potential dangers and perils of cut and paste through identification of patient specific instances impacting effective clinically truthful communication of fully informed coordinated quality care.

I would like to close by referring to the fact CDI as a profession can serve as a critical catalyst for meaningful change in documentation integrity by serving as a strong voice for the patient. Impressing upon the physician that the medical record serves first and foremost as a communication tool for the patient, the physician and all other relevant healthcare stakeholders is a reasonable place to start a discussion on appropriate use of cut and paste and carry forward practices. Take a close look at the “Safety Actions to Consider” piece of the Joint Commission article I referenced above. The CDI profession can be an influential force in starting the dialogue in our facilities to create, develop, implement and hold physicians accountable for adhering to an established policy governing cut and paste practices. We can’t solve the rampant use of cut and paste and other questionable documentation practices of physicians; just the same, we can take a seat at the table and serve as a true patient

advocate for accurate and complete communication of patient care. A logical place to start the long journey to slowly address cut and paste is the discharge summary where there is a strong tendency for physicians to basically cut and paste the entire history and physical and then refer to it as a discharge summary, leaving out key portions of the required elements of a discharge summary. Often, the discharge summary contains the results of labs and radiology reports for the entire admission yet overlook important diagnoses of record related to the admission and continued stay with final account of all relevant diagnoses that occasioned the admission.