

# Electronic Medical Records

## A Supplement to Medical Record Documentation *Adapted from MIEC online Resources*

*All documentation essentials that apply to paper charts should be included in an electronic medical record (EMR). The information necessary for optimal care should be documented no matter what type of chart is used: paper, electronic, or hybrid.*



### Specific security levels on a progressive need-to-know hierarchy:

EMR security should control specific levels of user access to protected health information (PHI); access authorization varies from clinicians to directors of departments to office administrators to front office staff, medical assistants and billing personnel. As required by HIPAA regulations, the level of access to information should be on a “need to know” basis and should be password-protected. Most electronic records have a tracking system to monitor who accessed a patient’s electronic medical record; systems should enable administrators to print a report of the date, time in, time out, and names of all personnel who accessed, changed or attempted to access patient charts.

**A default field for allergy information:** Users should be able to document allergy (or “No-Known-Drug-Allergy” [NKDA]) information in the allergy section of the chart. Some EMRs automatically transfer this significant information into all progress notes, the medication list, and the Problem List. Ensure that the EMR makes allergy information a default field (i.e., it cannot be overridden or skipped). Ask if the EMR alerts the user to known allergies, so a prescriber is notified when a medication to which the patient is allergic is entered.

**Patient health history questionnaires,** plus a means to enter evidence of physician review: Many medical practices ask patients to complete a questionnaire about their past medical and surgical histories, family medical history and personal habits. These can be helpful forms as they provide the physician with useful information. Once patients complete the forms and clinicians initial them as evidence of review, the questionnaires should be scanned into the EMR (or retained in the paper chart if the EMR lacks the capacity to scan documents). Some physicians document information from the questionnaires in the progress notes, a conscientious documentation practice that provides evidence of the clinicians’ review, and reduces the possibility that information is overlooked. Ask if the EMR has the capacity for computerized questionnaires (e.g., patients or staff members can electronically key in health information).

**A “Problem List”:** If more than one physician in an office or clinic treats a patient and makes entries in the EMR, the group may find a Problem List (that includes the dates of onset and resolution) helpful in managing serious or chronic medical conditions. A Problem List reminds co-treaters to review their colleagues’ progress notes and correlate their own treatment or follow-up advice. Caveat: Problem Lists must be current and complete or they could mislead. Physicians could consider assigning a staff member the responsibility of ensuring that the Problem List is current. E-signature and/or other means of finalizing entries so they are unalterable: EMRs vary in their use of an electronic signature. Some programs automatically track the date, time and author of every chart entry – a prudent feature – while others list only the clinicians’ names, but do not identify lower security level users. Some systems do not identify the author of the note until

the user electronically signs the entry. Some EMRs allow progress notes to remain “open” (not finalized; changeable) until they are “closed” via electronic signature; this is a dangerous feature and could call into question the veracity of the note (i.e., if a note can be left “open,” someone could change its contents, even after the patient suffered an injury).

All electronic entries, as with paper chart notes, should be generated contemporaneously to events, should clearly indicate who authored the note, and should be finalized / unalterable when the entry is completed, preferably the same date the entry was made. If a system allows notes to remain “open,” it would be prudent to establish an office policy that specifies a time frame within which the chart entry must be electronically signed and closed. Means to enter evidence of physician’s review of lab, X-ray and consultant reports: A number of patient injuries and malpractice cases are traced to physicians’ failure to review and act upon positive lab and X-ray reports, or treatment recommended in consultants’ correspondence, before these items are filed in the medical record. Currently, diagnostic test results and consultant communication are sent to physicians’ offices in various formats (e.g., fax, hardcopy, e-mail, digitally).



We know that many MIEC policyholders with computerized records are working with local hospitals, laboratories, pharmacies, and radiology departments to effectively interface. Until this goal has been achieved, physicians should consider the following:

**Hardcopy reports that will be scanned** – Physicians who have an EMR should initial diagnostic test results and correspondence received via fax machine or US mail before the information is scanned into the electronic record. Some offices scan reports upon receipt, send an e-mail or “task” to the ordering healthcare provider who electronically signs-off as evidence of review; the staff stores the reports with electronic signatures in patients’ charts. Either method is reasonable if the staff and physicians ensure that the diagnostic tests and consultant reports are consistently reviewed, initialed, and stored in the EMR.

**Digitized reports** – Physicians would be well advised to electronically sign lab or X-ray reports received via e-mail or digitally from local hospitals and ancillary services. Laboratory results submitted electronically enable some EMRs to store the data in a form that facilitates production of aggregate reports, a useful tool for physicians to track lab results over time, individually or collectively.

**Aggregate report capability:** The capability to collect and/or retrieve aggregate information is a vital function of many EMRs. Historical data (e.g., lab results, medications prescribed, missed office visits, and more) allow doctors to: monitor patients on the same medication regimen; identify patients on medications that are recalled by pharmaceutical companies; list patients who have missed numerous scheduled visits; monitor patients with certain medical conditions or who need health maintenance screening tests or follow-up diagnostic testing (e.g., mammograms; repeat Pap smears; liver function tests; thyroid tests; HgA1Cs; PSAs; INRs; prothrombin times); and more.

## Medication record at-a-glance:

Reduction of medication errors continues to be a focal point for patient safety nationwide. To assist physicians in their efforts to protect patients from injury and themselves from liability, the EMR medication management component should:



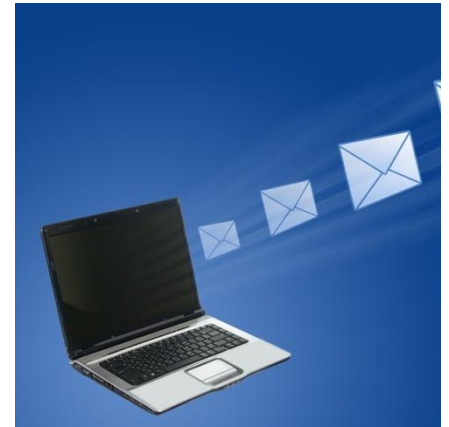
1. Prompt for all details of medication prescribing (e.g., name, indications, amount, dose, directions, number of refills authorized, etc.);
2. Monitor patients' current medications (e.g., medications prescribed by each treating physician);
3. Remind physicians of required lab testing intervals to ensure therapeutic levels (e.g., Coumadin, the statins, Lithium, etc.);
4. Alert prescribers to medication interactions or contraindications (e.g., drug-drug interactions; drug warnings for geriatric or pediatric patients);“ Reduction of medication errors continues to be a focal point for patient safety nationwide.”
5. Alert prescribers to drug allergies;
6. Track medication renewals;
7. Order prescriptions based upon medication formularies; and
8. Provide written patient educational materials to help patients understand the reason for the medication, comply with medication instructions, be aware of common side effects, know what to do in case of medication-related problems, and document that medication was dispensed. Physicians' progress notes should include the name of ordered medication, the dose, amount, instructions, reason for the prescription, and number of refills authorized. Discontinuation of medications should be documented clearly, as should the reason for any changes to medication orders. Physicians also decrease their liability exposure when they note and are attentive to medication management by other health care providers.



**A [tabbed] section for telephone messages**, if not entered chronologically in the progress note section: Phone calls in which physicians and/or staff receive or impart important medical information must be documented. Include the date and time of the call, the caller's name, contents of the conversation, advice given by the physician (or “per Dr. XX,” if provided by a non-licensed staff member), and the author's initials. To ensure accessibility to this significant information, consider where messages will be stored, and if they will be maintained under a dedicated tab and cross-referenced in the clinic notes, the progress notes alone, or in another consistent location.

## A [tabbed] section for e-mail between physician or physician's office and patient:

Documentation of electronic communication can be easier than telephone-based encounters. E-mail documentation reflects exactly what the patient asked and what the healthcare provider advised, unlike narrative documentation of phone calls stored only in human memory. Of note: Before using e-mail to communicate with patients online, consider the advantages and disadvantages. For guidelines to develop policies and procedures on the use of e-mail in your practice, see MIEC Claims Alert Special Report, Number 24A, *“Using e-mail to communicate with patients: What physicians should consider.”*



Physicians who choose to communicate with their patients via e-mail should ensure that the system is secure to protect patient privacy and maintain confidentiality. Similar to telephone calls, communication via e-mail should include unalterable information, including: the date and time the message was sent, contents of the discussion, details of advice given, and author's initials. E-mail communication between patients and healthcare providers should be retained in the EMR and/or filed in paper charts.

**Warning: “Deleted” e-mail is never truly deleted.** As “electronic discovery” becomes more common in malpractice litigation, any information stored on a hard drive or on back-up tapes can be retrieved, even if the data has been “deleted.” Be careful when using e-mail to communicate “internally” with staff. We strongly advise that all documentation in charts be objective and professional. Records subpoenaed in a lawsuit will include all information retained in the electronic system (e.g., the annotated version of the record).

The credibility of the information could be negatively impacted if there is evidence of subjective, contradictory, or unprofessional documentation. Customizable progress notes templates: An integral objective of most EMRs is to generate detailed progress notes quickly, notes that meet the various ICD-9 and CPT coding requirements and comply with Evaluation and Management (E&M) Medicare documentation standards. Similar to their handwritten counterparts, electronic progress notes should include sufficient information about:

- (1) Reasons for the current visit;
- (2) The scope of examinations;
- (3) Positive and pertinent negative exam findings;
- (4) Diagnosis or impression;
- (5) Treatment details and future treatment recommendations;
- (6) Medication administered, prescribed or renewed;
- (7) Written (or oral) instructions and/or education for the patient;
- (8) Details of referrals to specialists; and
- (9) Recommended return visit advice.

To meet the stated objective, many EMRs are designed to include specialty-specific templates, documentation tools that prompt clinicians to generate detailed notes based upon the patient's stated complaints or presenting medical condition. Some systems automatically populate fields with information that was previously entered (e.g., patient demographics, allergy information, current medications, etc.). Some EMRs have the capability to automatically generate a clinic note that replicates the previous office visit note. Once the new entry has been produced, it is up to the treating physician to delete those details that do not pertain to the current visit, commonly called "documentation by exclusion."

Although this automated feature may appeal to busy physicians, we warn doctors that "documentation by exclusion" may increase their liability risks if used carelessly and improperly. As with written notes, the EMR progress note must accurately reflect the details of the current office visit.

The screenshot shows an EMR interface for a patient named Ace Adams, 29 years old, male. The patient's primary insurance is Mega Life & Health. The current visit is on 02/20/2006. The subject line is "Persistent Cough." The history of present illness describes a 39-year-old male with a progressive cough, upper respiratory infection, fever, sore throat, and difficulty swallowing. The current medication is Nexium 20 mg 1 cap(s) once a day. The medical history includes HTN, CHF, and asthma. The ROS includes general, HEENT, cardiology, gastroenterology, and endocrinology. The objective findings include height 72, weight 165, BMI 25.09, temperature 98.7, BP 127/86, pulse 75, and respiratory rate 18.

Notes become suspect when each one includes identical levels of detail, especially if comparable to an initial consultation note or annual History and Physical report. It is "reasonable" for interim progress notes to include the patient's interim medical history, review of diagnostic tests completed between visits, physical examination, assessment and plan. When every progress note reflects a complete medical, social and family history, review of systems, etc., the information and the veracity of the physician's examination may be questioned. Bottom line: Be careful when "copying" previous visit notes unless their details exactly reflect the current office visit.

**Office visits at-a-glance:** The ability to see at-a-glance the dates of all office visits is a common feature in many EMRs; dates may be displayed on one side of the progress notes screen in chronological order. Clicking on the date opens the page containing a dictated note or scanned document. This is an excellent tool to assist physicians in their management of patients' medical complaints, reminding clinicians to revisit and address pertinent details and unresolved medical problems from previous visits. Diagrams: Does the EMR include anatomical templates, pictures that supplement narrative descriptions of the location of an injury or lesion? Does the system allow you to download pictures from a website? May the user enter digital photographs into patients' charts? EMRs should enable physicians to produce detailed chart entries that include visual supplements to expand the narrative description.

Office Overview		DOCTORS OFFICE	All Providers
<b>Upcoming Appointments (23)</b>			
9:00am - 9:15am	Charles, Michael	Roberts, Carl NEW PATIENT	✓ ☹
9:15am - 9:30am	Andrews, Jane	James, Roberts ESTABLISHED PATIENT	✓ ☹
9:15am - 9:30am	Imaginary, Susie	Roberts, Carl NEW PATIENT	✓ ☹
9:15am - 9:20am	Mctesterson, Susie	James, Roberts LAB	✓ ☹
9:30am - 10:00am	Stone, Johnathan	X-RAY	✓ ☹
9:30am - 9:45am	Mctesterson, Douglas	Roberts, Carl ESTABLISHED PATIENT	✓ ☹
9:30am - 9:45am	Cross, David	James, Roberts ESTABLISHED PATIENT	✓ ☹
9:45am - 10:00am	Sinclair, John	Roberts, Carl ESTABLISHED PATIENT	✓ ☹
9:45am - 10:00am	Brown, Mark	James, Roberts CONSULTATION	✓ ☹
10:00am - 10:15am	Singer, Carlton	Roberts, Carl PHYSICAL EXAM	✓ ☹
10:00am - 10:30am	Johnson, Ralph	X-RAY	✓ ☹
<b>Waiting (2)</b>			
	Janet Anderson	9:16am James, Roberts CONSULTATION	Move to... ☹ ✕
	Jennifer Tester	9:16am X-RAY	Move to... ☹ ✕
<b>Checkout (0)</b> (none)			
<b>BLOOD DRAW (1 / 3)</b>			
	Jane Andrews	04/26/2012 Roberts, Carl HEARING EXAM	Move to... ☹
<b>EXAM ROOM 1 (0 / 1)</b> (none)			
<b>EXAM ROOM 2 (1 / 1)</b>			
	Blue Test	04/26/2012 Roberts, Carl Lab	Move to... ☹
<b>RECOVERY (0 / 1)</b> (none)			

### Capacity to document failed, canceled and rescheduled appointments:

We recognize that most electronic systems are accompanied by a practice management component used to schedule appointments, document failed appointments, and more. Patients who consistently miss or frequently cancel appointments may place themselves at risk; some try to blame the physician for injuries caused by their own negligence. We recommend that failed appointments (e.g., “no shows”), cancellations, and rescheduled visits be documented in the clinic note section of the record, in addition to the practice management/scheduling portion of the program. Without the cross-reference, unless a physician regularly checks the scheduling portion of the EMR, he/she would not know how often the patient failed to keep appointments. If medical records are authorized to be released, the records should include appointment lapses.

**Documentation of patient education:** Educating patients about the nature and extent of an illness or disease, the proper use of medications, limitations on activities, dietary restrictions, the need for follow-up treatment, and more, can reduce patient injury and decrease physician liability. Malpractice liability experts, risk managers, and an increasing number of physicians, nurses and other health professionals acknowledge that patient and family education is an essential component of patient safety and quality health care. We know that clinicians, assisted by their staffs, spend a significant portion of their time orally educating patients. Documenting these discussions in the progress notes protects physicians from patients who deny they were informed about their condition and care. But oral communication is simply not enough in many instances. Some patients may not understand a technical discussion or may not be able to remember what the doctor said. Patients benefit from having written material they can read and review as often as they wish. Providing written educational materials also serves to educate spouses or adult children about patients’ medical conditions and care. The most effective EMRs offer printable patient education information. Some programs enable users to download information from websites and resources external to the program itself. Other programs have the capability of printing graphs depicting the patients’ weight gain/loss over time, blood pressure history, cholesterol levels, HgA1C, and more, all for the purpose of educating patients about their overall health. Documenting that information was distributed provides evidence of a physician’s efforts to educate patients orally and in writing. It passes responsibility to patients for cooperating in their own health care.

### We recommend:

- Treat EMRs with the same gravity you would paper charts.

- Review with patients their medical histories, what other doctors they see, and what medications they take; document their responses.
- To the extent possible, ensure that the EMR has reasonable levels of security to protect against inappropriate disclosures.
- Request authorization from patients to review other providers' documentation. Even though this information is accessible to you under HIPAA and most states' laws for treatment purposes, asking patients for their authorization makes obtaining the information an open transaction – no secrets.
- Review and consider EMR documentation as you would paper charts.
- When in doubt about what you've read, the impact it has on your patient and your care, and what you may do with the information, call MIEC to discuss the nuances of the situation.
- It is impossible to foresee all the potential pitfalls of shared electronic medical records. For instance, what will physicians on a shared system do when a patient wants to prevent a particular physician from accessing his/her information? What if a physician inadvertently acquires significant information from the EMR not disclosed by the patient and acquired without the patient's knowledge? What if information given to two physicians by one patient is contradictory? These and other questions have yet to be answered. When in doubt, call MIEC.

Potential advantages of an EHR:	Potential disadvantages of an EHR:
<ol style="list-style-type: none"> <li>1. Decrease number of charts pulled</li> <li>2. Increase efficiency</li> <li>3. Decrease the cost of transcription</li> <li>4. Increase coding efficiency</li> <li>5. Access aggregate information</li> <li>6. Easier access to charts — fewer lost, remote access</li> <li>7. Improve interoffice communication</li> <li>8. Improve documentation of care provided</li> <li>9. Facilitate improved delivery of patient education</li> <li>10. Improve management of patient demographics</li> <li>11. Improve management of medical conditions, health maintenance, etc.</li> <li>12. Improve management of medications (e.g., e-Prescribing)</li> <li>13. Decrease in Rx and documentation error rate</li> <li>14. Increase intra- and inter-facility communication (on network)</li> </ol>	<ol style="list-style-type: none"> <li>1. May decrease face-to-face time with patients, depersonalize encounters</li> <li>2. Possible lack of connectivity and interoperability</li> <li>3. EMR may be obsolete within a few years</li> <li>4. System relies upon user integrity (i.e., garbage in = garbage out)</li> <li>5. Potential for exaggeration, dishonesty and other abuses</li> <li>6. May not enhance delivery of care</li> <li>7. Often excessive time and energy for transition to paperless system</li> <li>8. Increase costs</li> </ol>

## How to reach MIEC

Oakland Office *510/428-9411*

Outside: *800/227-4527*

Loss Prevention Fax *510/420- 7066*

Main Oakland Fax *510/654- 4634*

Email:

[Lossprevention@miec.com](mailto:Lossprevention@miec.com)

Email: [Underwriting@miec.com](mailto:Underwriting@miec.com)

Email: [Claims@miec.com](mailto:Claims@miec.com)

**6250 Claremont Avenue  
Oakland, CA 94618**

**Phone 800-227-4527**

**Fax 510,654.4634**

