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Consider 4½ Keys to Documentation As EHR Flaws Become Apparent

Electronic health records don't always paint the kind of picture that auditors need to determine whether there's support for the services billed to Medicare or private payers. The documentation may fail to connect the dots between the patient's problems and their risks, a gap that persists with paper charts as well.

"Documentation has deteriorated significantly over the past 10 years," John Zelem, M.D., an executive medical director at Executive Health Resources in Newtown Square, Pa., said at a Feb. 7 Finally Friday webinar sponsored by the Appeal Academy. "One of the greatest things to happen as far as helping documentation is EHRs, but one of the worst things for not helping with documentation is EHRs."

EHRs have their advantages, such as legibility, but there are disadvantages. For example, in the assessment and plan, the use of problem lists is helpful in terms of physician thinking, but they don't tell auditors or other clinicians the whole story, Zelem says. They list the patient's problems without drawing conclusions about them or saying how one problem affects another. The physician ticks off the problems — a perirectal abscess, hypertension, diabetes, atrial fibrillation and chronic obstructive pulmonary disease – "but no one documents the fact that the diabetes presents a significant risk with perirectal abscess because that patient could go into necrotizing fasciitis even while treatment is rendered," Zelem said. "The pieces of the puzzle are present, but nobody constructs the picture with the pieces."

Many H&Ps Are Sketchy

About one third of the charts Zelem reviews have sketchy history and physicals (H&Ps), which are "the main storytellers that get looked at by auditors." He said there are 11 elements in the history and physical: chief complaint, history of present illness, past medical and surgical history, social history, review of systems, vital signs, physical exam, labs, X-ray/EKGs/other diagnostic tests, assessment, and plan. Often the chief complaint — the reason why the patient is at the doctor's office or hospital — is AWOL. "As I look at charts, it's amazing what's missing," he said.

Often the review of systems (ROS) is inadequate, Zelem said. Physicians use the review of 12 systems (e.g., cardiac, circulatory, gastrointestinal) to get a medical history from patients. But instead of being specific, physicians may state "review of systems as per nursing notes" or "all 12 elements looked at and reviewed." That may not fly with auditors and it doesn't do much to communicate with other clinicians, Zelem said. "If I were reviewing those charts for payment, I would deny all of them. The review of systems is an important part of the chart," he said. "If it is not written, it has not been done." He recently reviewed a chart that said vital signs were taken, but only reported the patient's blood pressure, oxygen saturation and pulse. "Don't patients have temperatures? Don't they breathe?"

Improving documentation isn't rocket science, he says. "Good documentation is part of good patient care," Zelem says.

There are four and a half keys to physician documentation, Zelem said, and they focus on the assessment and plan of care:

(1) Suspects: What do I suspect is wrong with the patient? "During questioning, we develop a conclusion of what might be going on. We go down a path to develop suspicions," he says.

(2) Concerns: What are you concerned about that can go wrong? "In our mind, we are risk stratifying these patients, developing concerns about what could go wrong based on our training, experience, the literature and conferences."

(3) Predictable risks: How predictable are those concerns?

(4) Intent for treatment: How will I treat the patient and will hospital-level care be required for two or more midnights? This is where the four-*and-a-half* comes in: the word "because" is very useful in telling the story in documentation. "I am ordering this test because..." or "I am keeping this patient in the hospital another day because...." Zelem says he tells physicians "you don't have to create a 12-page epistle. But you have to have a diagnosis, not a symptom, and say whether the patient is at

high or low risk and what the plan of care and treatment includes and also the intent for a two-midnight stay."

For example, the physician would cover all the bases by writing "inpatient care is warranted for this 79-year-old female because she presents with substernal chest pain made worse with exertion. She has diaphoresis, abnormal EKG, and I have a high level of concern for unstable angina because this patient is at high risk for myocardial ischemia." If the physician adds a plan of care, he or she will have documented everything — suspicions, concerns, risks and an anticipated two-midnight stay. "This is one paragraph summarizing the entire H&P into what you are thinking so someone else can read what you are thinking," Zelem said. That's more than a problem list, he noted, which doesn't connect the concerns and risks. His four and a half keys are similar to the classic "SOAP" — subjective, objective, assessment and plan — fundamentals.

How much physicians can improve their EHR documentation depends on whether their software can be customized. Free texting gives physicians a chance to explain their thought process, but their EHR vendor and IT department have to make free texting adequate, Zelem says.

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