EHR's troubled path: Three persistent problems

Technology changes at what can seem like light speed. ACDIS released a white paper on the topic of electronic health records (EHR) in 2013, and anyone working in CDI knows that, though some things remain constant, a lot has changed since then.

The three issues that CDI professionals most often cite when it comes to EHRs are templates, copy/paste, and the problem list. Each of those components can lead to costly mistakes in the record, throwing off coding and reimbursement and possibly introducing patient safety risks.

So,how can CDI professionals limit these types of issues? Three members of the 2018 CDI Practice Guidelines Committee weighed in for this edition of the *CDI Journal* to light readers' paths to a better EHR.

Physician template use

To cut down on burdensome documentation requirements, most EHRs incorporate templates for providers to use. These templates may ease the documentation burden for physicians, but if they weren't set up to capture the information needed for accurate documentation, they can steer CDI professionals reviewing the record in the wrong direction.

"When an organization implements an EHR, everyone is very focused on the processes, access, and learning the new system and not focused on the content of the provider templates," says **Karen DiMeglio, RN, MS, CPC, CCDS**, director of CDI and appeals at Lifespan in Providence, Rhode Island. At her facility, "CDI wasn't involved and now we're left with templates that have a ton of information in them but don't always include the necessary information for diagnoses and quality measure capture. In fact, we have found some templates that [auto]populate diagnoses but are not always appropriate for that individual patient."

The template may also pull information from an incorrect location in the EHR, DiMeglio adds. So, CDI departments should investigate the use of smart links and where in the EHR is getting the information from. Smart links are shorthand words that a physician would use during documentation to automatically pull certain information into the medical record. For example, if physicians need to insert labs into a note, they might enter "lastCBC" and the information pertaining to the patient's blood work would be inserted into the record.

"We discovered that the providers were using the wrong smart link to pull in the problem list. Diagnoses that weren't relevant to the encounter were coming into the notes," she says. "The providers didn't even know they were pulling in the wrong list. Providers are busy, so when there's a quick link they can use, they use it." Making sure that links are set up correctly is paramount.

Knowing the problem exists is the first step to fixing it. The next step, according to DiMeglio, is to work with providers and make sure the templates work for your purposes and theirs. Throughout the process, make sure to highlight the why behind suggested changes.

"We have to consider the burden that the EHR has caused our providers," she says. CDI professionals need to frame the conversation by acknowledging that burden and explaining how such changes may help reduce the need for additional documentation and/or queries. In addition, CDI professionals need to find ways to leverage the technology for accuracy and efficiency. For example, a smart phase could be implemented to pull in the registered dietician's notes when they categorize the patient as having malnutrition.

"CDI needs to be involved with the process of adding new shortcuts in the EHR," says DiMeglio. Otherwise, the issues are likely to persist.

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CDI template use

Physicians aren't the only ones with template issues. When EHRs took hold in the industry, many CDI departments moved their querying process to the electronic system as well, building in query templates and the like to streamline their query processes and reporting. Just as CDI staff generally weren't involved in developing the physician-facing templates, physicians were rarely asked their opinion on the templates CDI programs developed.

"When we started out and templates were being used, I don't think any of us had the mindset to sit down with a group of physicians and ask them what they actually thought was important," says **Sharme Brodie, RN, CCDS**, CDI education specialist at HCPro in Middleton, Massachusetts. "A lot of the physicians I've talked to would do the templates very differently if they had the chance."

For example, query templates are often formatted with the clinical indicators listed first, followed by the question a couple of paragraphs into the query. According to Brodie, many physicians would prefer that the question be listed first, with the clinical indicators following for reference.

A recent Q&A with the ACDIS Advisory Board reveals that many organizations have switched their query format to put the question first as it helps "busy providers focus and get straight to the issue at hand." Really, though, this is a matter of preference and has no effect on the compliance of the query itself. "The elements that comprise the entirety of the query, including the supporting clinical indicators, determine its compliance, not the sequencing of those elements," the Advisory Board wrote.

CDI teams should work with providers to create query templates that are as straightforward and understandable as possible for busy physicians and then work with the compliance and IT departments to implement those changes.

Copy/paste

Ask CDI professionals about their EHR woes, and they're sure to mention copy/paste concerns. In some instances, copy/paste functionality can reduce the time physicians have

to spend documenting; however, it can lead to dangerous shortcuts when the pasted information is not updated appropriately from day to day.

"When you see the breakdown between what's new information and what's been copy/pasted, it's overwhelming," says Brodie.

There are a couple ways to combat this issue, according to DiMeglio and Brodie. The first option is to enact policies that limit which parts of the record can be copied from or pasted into. However, unless there's an option to actually disable the copy/paste function in certain parts of the record, physicians may still find ways to use (and abuse) the functionality.

"Many people will carry over the note and then just update it slightly, which can also get you in a lot of trouble," DiMeglio says.

The prevalence of denials is putting the copy/paste issue in the spotlight, too, says **Lisa Romanello, RN, MSHI, CCDS, CDIP**, CDI manager at Prism Healthcare Partners, Ltd., in Glen Allen, Virginia, which makes it a good time to broach the subject and make some changes.

"I saw a denial not too long ago where the medical reviewer said that the whole chart was copy/pasted and nothing was changed each day," Romanello says. "We took it to the chief and told him that you cannot copy/paste the same information every day without documenting that the level of service has changed."

"If I was an auditor looking for reasons to deny a claim, I would certainly be paying attention to charts where it appears the bulk of information in the record is copy/pasted from the previous note," Brodie agrees. "I always suggest that anyone reviewing the medical record pay attention to not only what the body of the progress note states, but compare it to what is documented in the review of systems (ROS). I've reviewed many records where the ROS states all systems are within normal limits, but when you read the actual note, it tells a very different story, or vice versa. You may have a copy/paste issue on your hands."

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Because policies around copy/paste may have limited success, Brodie posits that a more extreme approach may be warranted to avoid the worst kind of mistake: patient harm.

"Some facilities have cut off the ability to use that function, and that may be the best option, honestly," she says. "I think it may take an overwhelming accident where someone is going to give a physician information from the record that they think is new and updated and somebody is going to find out that it's actually two weeks old. When that happens and results in death, just like the Surviving Sepsis Campaign, that's when I think there will be real universal change."

Problem lists

It's a cliché for a reason: There are some serious problems with the problem list. "So many times you look at the problem list and you see diagnoses that could be from 10 years ago," says Romanello. "I find myself asking why we're listing a UTI [urinary tract infection] on the list that was cured five years ago."

The problem list is typically so messy that many organizations have policies that say their coding professionals cannot code from it. "Nobody's ever able to cite the source for coding or not coding from the problem list, though," says Brodie, which means the decision is often left to the individual organization. "It amazes me that CDI is not addressing the problem list more."

That attention is beginning to shift, however, because of increased outside scrutiny, Romanello says. "The volume of denials hospitals are getting because diagnoses are being pulled from the problem list is really highlighting the issue now," she says.

"We're very skittish about coding anything from the problem list because we're heavily audited," agrees DiMeglio. "There have been mistakes before, and even if the

diagnosis is correct, we'll still have to write the appeal letter."

To deal with the problem list, organizations can enact policies laying out who is responsible for adding and removing the list's diagnoses. This helps CDI professionals know, at the very least, whom to contact with questions about the list.

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For those with EHRs that include artificial intelligence, Romanello encourages CDI leaders to investigate where the problem list is pulling its data from. "A lot of doctors don't realize that some EHRs pull diagnoses from the outpatient setting and they're just not appropriate for inpatient stays," she says.

DiMeglio suggests working with the IT department to correct this issue. "We had to put a fix in place so that the only diagnoses on the problem list are specifically from the hospital list."

For a unilateral approach, Romanello suggests taking a cue from the annual nature of Hierarchical Condition Category (HCC) capture. "I almost wish that a patient's problem list could be like the HCCs so that at the end of the year, it would wipe clean besides any chronic conditions and you would have to start fresh," she says.

If that approach ruffles too many feathers, however, try a scaled-back approach. "There are policies out there where after a certain period of time, all infections will fall off the problem list because, by nature, an infection is temporary," DiMeglio says. "Getting the healed infections off is a good start, but then you need to get some of the other acute diagnoses removed after a certain period of time if they've resolved."

Education as antidote

While policies and IT fixes will solve some of the most egregious EHR issues, the heart of the issue is education, Romanello says, even if your CDI team is going remote.

"Now that we have the EHRs, many CDI specialists are not leaving their offices to interact face-to-face with the physicians," she says. "Even if you're only on the floor a couple days a week, the physicians will become comfortable approaching you when they have questions." If you're already remote, remember to be in constant contact with the physicians over the phone or Skype to maintain the relationship outside of the query process.

And it's not just the physicians who need EHR education, Brodie says. "You should also get involved with informatics. A lot of organizations are sending their informatics people to CDI and coding education so they know what's needed in the EHR," she says. "Have them attend when there's CDI education or maybe send them when they first start at the organization."

The CDI team can also be the go-between for the informatics/IT department and the physicians, making sure the physicians understand the new updates and how to use them, Romanello says.

"You have the new information and you can go out there and tell the physicians about it," she notes. "They're so busy that they don't always have time to read all the information coming to their inboxes. And even if they do, they may not really comprehend what it means for them."

Though the issues with the EHR won't be solved overnight, and template use, copy/paste, and the problem list will likely continue to make appearances on CDI professionals' list of grievances, CDI's involvement in building the solutions to these issues cannot be overvalued. By nature of their daily efforts, CDI professionals are trusted allies for the physicians in the trenches of EHR nuances.

"Remember that the education piece is the part of CDI that separates you from many other departments," says Brodie. "It's what makes you valuable to the organization and to the physicians."