

Q&A

Electronic health records



As part of the third annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. **Juli Bovard, RN, CCDS**, clinical documentation specialist in the Clinical Effectiveness/Clinical Quality Department of Rapid City (S.D.) Regional Hospital, answered the following questions regarding ICD-10 preparation. Contact Bovard at jbovard@regionalhealth.com.



What have been the biggest challenges with implementing an electronic health record (EHR) in your facility?

For our facility, I think the biggest challenges with implementing the EHR is engaging all disciplines who have privileges at our organization. Having the patient information/profile/labs available in the computer has not been so much of an issue as the expectation that all providers will actually document within the electronic medical record.

I think most providers find the transition from paper lab reports, radiology tests, etc., to having them all in the computer an easy process. Currently we are still hybrid and still maintain a paper chart. Many of our providers (other than our hospitalists) are still documenting on paper in the paper chart, and I think that is a detriment for physicians to have to go back and forth from chart to EMR to see the full picture of the patients' status.

to print off in paper form. Having the ability for multiple providers to be able to view the entire picture of the patient without having to have a "chart" in hand is immeasurable.

Gone is the world where a doctor has to make multiple attempts to find the patient, or patient's chart, to write orders or see what orders were written by consulting providers. If a patient is off the floor getting testing done, having surgery, in dialysis, etc., a provider can still go view their patient status; read nursing notes; find issues with wound care, nutrition, I&O; and even submit orders, change medications if needed. You can get a feel for the patient's status and issues all in one place. A provider can go to any computer and have quick access to their patient's information without having to hunt down a chart.



What are some of the drawbacks of the EHR? Have you had any problems with copy/paste?

Currently, we are still hybrid—using both paper charting and computer charting. Most of our consulting physicians are not documenting in pDoc ("computerized physician documentation" in our Meditech system). This creates the dilemma of anyone needing information on the patient of having to spend time in both the physical paper chart as well as the computer chart in order to read



What are some of the benefits of the EHR?

Having all the patient's test results, H&P, consults, dictations, labs, past visits, etc. all in one place for a provider to look is a huge benefit—no need to wait for a lab result or radiology results

consults, notes, dictations, etc. I think this creates a break in communication for the providers and creates an issue for the patient related to safety and care. Imagine if a patient's status declines—a provider then has to be in both the computer and the physical chart to try and evaluate what has gone on with the patient related to what consults have documented about patient status, etc.

Copy/paste is a huge issue for our institution, as I understand it is for others as well. I feel the providers should not have the capability to do this—I think the function/ability should be turned off altogether. It creates a huge legal and risk issue for providers. It continues to give physicians the ability to carry forward incorrect and erroneous information. I think it is a detriment, especially for institutions that are teaching hospitals, because it negates the need for residents to perform independent thinking, and appropriately perform assessment and document their own findings. Legally, it seems to me this places the institution at risk. In the very near future, I think it is really going to be an issue with RAC audits and therefore negatively affect reimbursement, pay-for-performance, and value-based purchasing. Knowing this, eventually, I feel it will be turned off and providers will not have the ability to use the copy/paste function.

Q **How has physician response been to electronic queries, as compared to printed forms or verbal discussions?**

A *We are currently building our e-queries in Meditech. We also use DRAGON® for voice recognition software to document, or they can type if they choose.* Considering we are promoting an all-electronic record and want our providers to use CPOE/POM and pDoc, it only seems the natural progression of things. I am surprised it has taken us this long to implement it, though I understand our current version of Meditech has limited us in this field. I think it is going to be much easier to track queries and the provider responses once the queries are electronic.

My fellow CDIs and I are all very excited about this process, as are the providers we have spoken to. We will trial the e-query in late August with a group of providers to work out the kinks, but are looking forward to being able to use them! I think we have to get all providers documenting electronically for it to be most successful, but I understand progress takes time. Eventually, we have been told that provider responses will be tied to their incentives and annual evaluations—so that is a good thing. If the queries not being answered negatively impact quality and reimbursement of an institution, that should flow over to the provider who did not answer the query that led to that negative impact.

Q **What are your thoughts on CDI specialists performing remote reviews of the medical record?**

A *The CDIs that I work with and I have actually had this discussion.* We have and continue to work long and hard to get the providers to recognize who we are and what we do. Working solely from home, we feel, would have a negative impact on what we have worked so hard for.

However, having said that, we understand the dilemma—that once the entire chart is computerized, there will be less day-to-day interaction with physicians. While we don't agree with doing all work from home, we feel there is a place for limited workplace interactions. We basically are reviewing them "remotely" from our office now as it is. In the future I can envision having limited or variable schedules that would allow a CDI to work part-time from home and part-time from the hospital, while still having at least one or two CDIs in house with rotating schedules. We could still come in and educate new providers on our programs, attend the provider meetings, and continue to make ourselves available to physicians—but also have some flexibility that an all-EMR would allow.