

Electronic Health Record Documentation Bad Habits: How Shortcuts Pose Risk

Anne Frunk

University of San Diego

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In today's world, medical providers often face burnout, time pressures, and difficult productivity expectations. Lack of standardized electronic health records (EHRs) documentation training result in unstructured data entry and compromised medical records that lead to patient safety issues. Staff members and providers must be trained to use EHR features to which they will have access (Pepper, 2020). Papadakos (2018) wrote, "human-to-technology interfacing should have a major role in training providers to recognize, evaluate and correct faults in computer records, guarding against errors and increasing patient safety, which could prevent legal misadventures."

Accurate, timely, and complete documentation is the foundation for maintaining patient safety, a robust quality management system, and supporting reimbursement for services rendered. Accurate documentation is vital to ensuring the highest level of patient care, and a complete medical record is the primary source of the patient's medical history and office visit notes (Pepper, 2020). Health care professionals aim in adopting EHRs was to improve patient safety and accessing patient data elements easier; however, learning how to properly document in the EHR may not always be as easy as medical personnel would like. EHR workflow and design should avoid shortcuts that create bad documentation habits, leaving health care organizations and providers vulnerable to accusations of fraud.

In this paper, I will discuss how EHR bad documentation habits and shortcuts apply to patient safety. Various factors play a role in poor documentation and can negatively affect physician referrals, continuity of care, and even patient outcomes. Common areas of risk include the absence of chief complaint or a history of present illness, information automatically carried forward from last visit but not reviewed, only recording positive findings, lacking an assessment or incomplete assessment, using the same list of diagnoses for every patient and documentation

that doesn't support the level of care provided (Fucinari, 2016). Patient safety is one of the many reasons ensuring clinical documentation meets medical necessity. Because providers' code and some EHR systems are set up to assist with coding, it is critical that providers focus on proper documentation and understanding coding and the risk of how it affects patient care.

Literature Review

To understand the correlation of bad EHR documentation habits with patient safety, we must also explore what is required of proper documentation. Three general themes should be applied to documentation: (a) the documentation tool (i.e., EHR) is adapted to the clinical practice; (b) providers document to improve patient safety, and legally protect themselves and the organization; and (c) follow traditions, standardization, and conditions for documentation guidelines. Providers' subjective perceptions of and opinions on the effect of documentation influence documentation practices, which are widely governed by habits and traditions (Frederiksen, Lorentzen, Sondergaard & Sorensen, 2017). Subjective understanding is antithetical to the objective goal of standardization and adherence to the norms of best practice. This is a point of tension between medical providers, historically comfortable with their autonomy, and administrative leadership in the post-EHR landscape. The goal of this literature review is to compare documentation infractions with their associated impact to patient safety.

It is important for organizations to first identify areas of opportunity and conduct an organizational assessment to gauge risk. To mitigate risk, evaluate the history of the organization and culture, shadow various department workflows, understand EHR functionality, learn coding and billing practices as they apply to organization type, and develop an audit plan taking all these aspects into consideration ("Step-by-Step Process," 2004). According to the American Health Information Management Association (AHIMA), EHRs are key to controlling

fraud costs because of audit trail capacities and other technology features. When used properly, EHRs have the potential to vastly improve documentation and patient safety (Dimick, 2008).

As you begin to assess contributing factors of poor documentation habits, we learn EHR functionality can be a direct cause and providers must be given the tools they need to navigate these systems. Han and Lopp (2013) stated poor documentation and adverse patient outcomes correlate with low EHR computer navigation skills. The regression model result was R^2 0.35 (F14.6, pB0.001). The length of EHR experience (t2.5, pB0.02) and the EHR navigation skills (t5.1, pB0.001) were found to significantly contribute to the regression model. Rowlands, Coverdale, and Callen (2016) concluded on-the-job education with feedback in clinical documentation and EHR functionality provides a learning opportunity for medical students and is essential to ensure accurate, safe, succinct and timely clinical notes. If we can educate providers in medical school and residency programs early on, we can help reduce the steep learning curve in the future of practice. A medical student stated, “you’re always told it is important but yet we don’t have any teaching on it” (Cheng, Gilchrist, Robinson, & Paul, 2009). Teaching programs must evolve to put extra energies into the modern tools in practice if it is to improve risk management. It is not surprising that the literature shows lack of training in EHR practices adds to poor documentation outcomes.

In addition to the complexities of EHR comprehension, another patient safety issue is lack of documentation supporting medical necessity. A study published in the *Health Information Management Journal* stated incorrect selection or coding of the principal diagnosis accounted for 13% of the diagnosis-related group (DRG) changes and missing additional diagnosis codes for another 29% of DRG changes. The results of the literature findings show coding errors and DRG changes resulted from poor quality of documentation. The study

concluded that the auditing process plays a critical role in identifying causes of coding inaccuracy and poor documentation (Cheng et al., 2009). Furthermore, the Australian Commission on Safety and Quality in Health Care recognized the relationship between effective documentation and patient safety, with evidence showing poor documentation can lead to adverse events. The study also noted poor documentation often resulted from missing or miscommunicated information (Hay, Wilton, Barker, Mortley, & Cumerlato, 2020).

In conclusion, these studies have shown the importance of how documentation contributes to patient safety outcomes. Solutions include with having a robust training program early in the medical education process to assist providers in EHR functionality and coding education program. In addition, the literature review shows it is essential to also have an auditing compliance plan to help mitigate risks and provide learning opportunities for providers. If we can provide robust training during onboarding and in residency programs that demonstrate proper documentation protocols within the EHR, we can improve documentation and in turn promote patient safety.

Identified Solution

Accurate and complete documentation is an integral component to the delivery of quality health care (Mathioudakis, Rousalova, Gagnat, Saad, & Hardavella, 2016). To avoid documentation pitfalls and promote continuity of care and patient safety, the curriculum of the medical student will include exposure to proper data capture and the keeping of detailed, specific information in the patient record. Teaching this in school prepares the provider with a good foundation of documentation best practices. In addition, it prepares providers what may be expected by future employers, insurance companies, and government entities.

Health care organizations can also strengthen good documentation practices by developing a robust provider onboarding program and having strong policies and procedures. As

mentioned above by Rowlands, Coverdale, and Callen (2016), clinical EHR trainers in partnership with coding educators facilitate guidance and feedback on various patient care scenarios attributable to the provider's specialty. While delivering training on proper documentation and coding, simultaneously incorporate proper navigation and use of the EHR by an EHR superuser, the provider learns both EHR functionality and accurate documentation synchronously. Guidance from EHR superusers along with clinical documentation improvement experts can greatly improve provider documentation practices (Cheng et al., 2009).

Clinical documentation education and doing a deep dive each year into the annual state and federal requirements including but not limited to code updates, regulatory directives and changes in scope should be conducted. Annual small group or individual trainings can also enhance diagnosis documentation and improve quality outcomes. If a provider uses a scribe, they should also be included in the training. This should be an organizational effort with buy-in from all levels. Clinical documentation improvement programs serve as the roadmap to cultural change that can improve patient safety, continuity of care, quality outcomes and help support reimbursement.

Prior to implementing a solution, a failure mode and effect analysis (FMEA) was conducted. The first step is to create a process map of steps to visually show potential solutions (see Appendix A). Second, a list of potential errors is determined (see Appendix B). Finally, a FMEA illustrates processes for preventing potential causes of errors identified (see Appendix C).

Quality Measure

Performance Measure

Health care organizations research state and federal requirements when deciding on standard performance measures. Chapman (2018) noted the Office of Inspector General (OIG)

recommends physicians maintain an accuracy rate of 95% for coding and documentation. The performance measure for this paper aligns with the OIG's expectation.

Although coding and documentation are linked, they do not always directly impact each other. For example, if a charting issue results in a coding issue, both are noted as errors. Coding could be anything from the E&M level submitted to the diagnosis used while charting is how the information was entered to overall template utilization. Some examples of coding and charting errors are presented below.

Coding only items:

- Provider selects one level of service while another is supported by documentation.
- Charting details are correct, but the ICD-10 code selected does not correctly apply coding guidelines. (i.e., bilateral knee pain but only right knee was coded)
- Provider notes the procedure performed, including method and supply, but the codes are not submitted for billing. This is defined as a coding error as documentation is correct.

Charting only items:

- The assessment and plan section do not provide details to support the diagnoses selected, but coding is still appropriate as an auditor can confirm the condition through history or examination components.
- Coding is correct but unable to confirm proper provider due to undocumented credentials or signing provider(s).
- Provider does not use the system-built templates or modules to report data thus, the auditor or other third party must hunt for the supporting information to confirm proper coding.

Performance Measurement

The performance measurement process begins with a baseline coding and documentation audit of all providers. The baseline audit examines and identifies areas of risk that may contribute to non-compliance and areas of opportunity for improvement. Health care organizations may choose to manage this process in-house, contract with a third-party auditor, or use a hybrid of both. The option chosen by the organization will determine who is responsible for pulling data and auditing medical records. The results will be used to evaluate workflows, operational processes, and develop education and training programs aimed at improvement. Random chart audits conducted on a quarterly basis will trend results and identify areas of future focus as well.

Performance Management

It is difficult to obtain a 95% coding and documentation accuracy. A coding and compliance auditing plan will set the tone for expectations and developing EHR and coding and documentation training programs. A strong provider onboarding program early on will assist in mitigation of coding and documentation errors. It is equally important to conduct annual training to all providers as updates and upgrades occur. Ongoing monitoring and auditing along with proper training will assist in evaluating the effectiveness of standardizing processes and the adoption of clinical practices promoted by the quality measures.

Conclusion

Key factors such as documentation training, standardization of EHR workflows, and strong communication play an important role in eliminating bad EHR documentation habits. It is a collaborative effort between providers, human resources, compliance experts, and training teams to combine curriculum, onboarding standards and procedures, and training materials. Furthermore, it is joint effort with EHR superusers and clinical documentation improvement

specialists to align both clinical and organization practices. An organization looking to avoid or minimize documentation errors can begin with a compliance taskforce that develops an auditing and education plan. The compliance taskforce is a diverse multidisciplinary team that considers a variety processes to help create a standard operating procedure consistent with practices across the organization. As we look to the future, residency teaching programs should also include modern tools and exposure to risk management. All of these concepts and objectives will assist in reducing documentation errors that impact patient safety.

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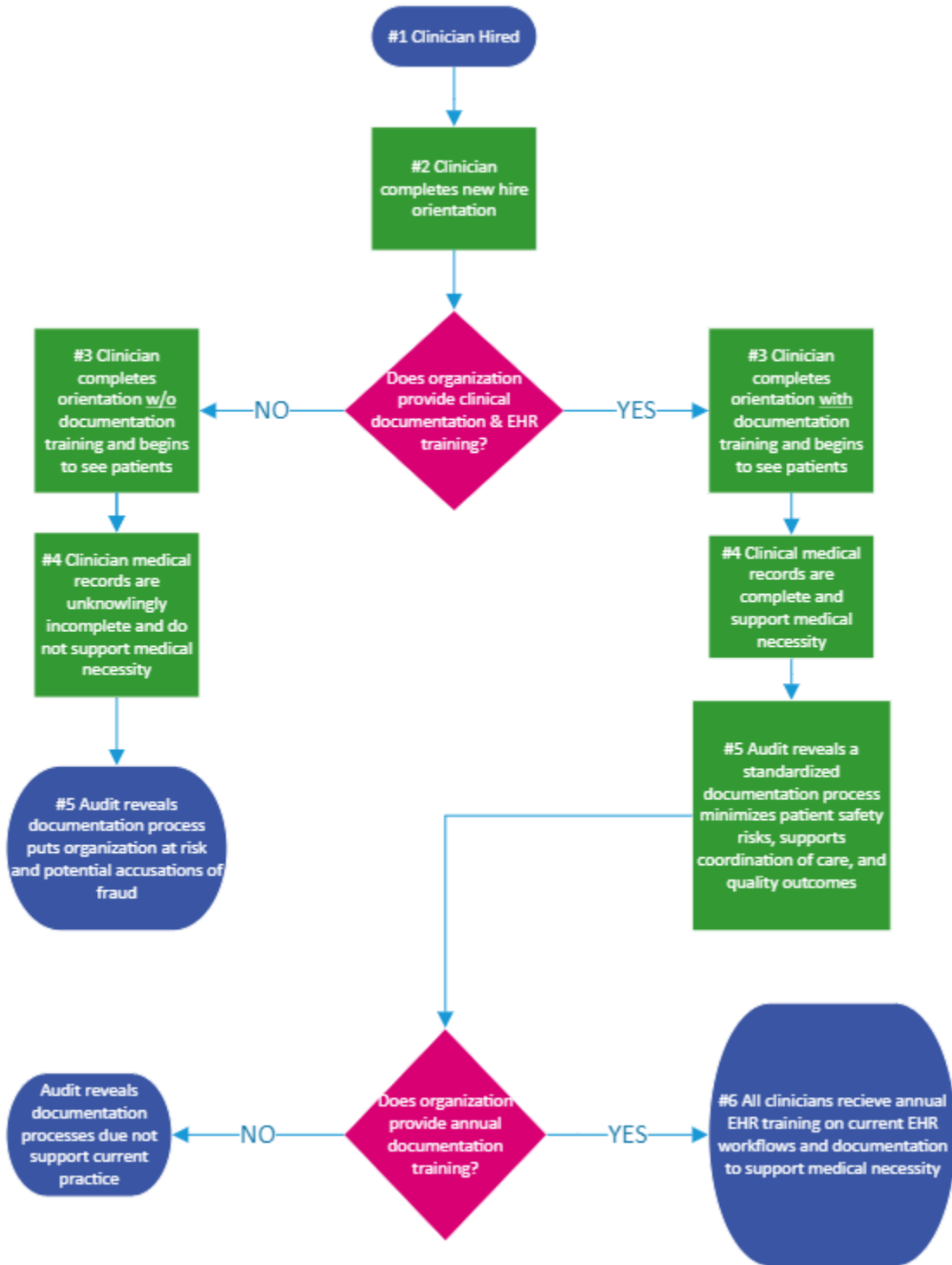
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Appendix A

Clinical Documentation Training Process Map



Appendix B

Potential Errors Identified

	1	2	3	4	5
	Provider hired	Provider orientation	Provider training	Provider begins to see patients	Audits conducted
Potential errors	Not all stakeholders are aware of newly hired providers; Notification of new hire not sent to appropriate stakeholders, IT, Informatics, Billing	Provider orientation does not include introduction to type of facility and background, mission and values	Provider training does not include review of organization, state and federal regulatory documentation requirements	Scribes not trained on proper documentation practices	Audits are not conducted
	Provider not set up in EHR system as a rendering provider	Provider orientation does not include documentation workflow training	No EHR training department	Documentation does not meet medical necessity for services rendered; missing or incomplete medical records	Audit sample size is too small and not enough to identify gaps in training
	Provider not credentialed or enrolled into payer programs	Provider Orientation does not include EHR workflow training	No EHR Superuser(s)	Lack of provider support	Feedback is not provided to providers

Table 1. Potential Errors Associated with Implementation of Clinical Documentation Training

Appendix C

Clinical Documentation Training

Failure Modes and Effects Analysis (FMEA)

Table C1

Process step #1	1	Process step	Provider hired		
	2	Potential failure mode	Not all stakeholders are aware of newly hired providers; notification of new hire not sent to appropriate stakeholders, IT, informatics, billing	Provider not set up in EHR system as a “rendering” provider	Provider not credentialed or enrolled into payer programs
	3	Potential Cause(s)	Poor communication from HR	Short staffed and silos	Organization not aware of timeframe or steps to complete
	4	Severity	7	6	5
	5	Probability	6	5	4
	6	Hazard score	42	30	20
	7	Action (eliminate, control, or accept)	Control	Eliminate	Control
	8	Description of action	Identify all stakeholders involved and review process on notifications	Identify what information is required to add provider to EHR; NPI, DEA, License number, taxonomy	Meet with RCM team and stakeholders to complete processes

Table C2

Process step #2	1	Process step	Provider orientation		
	2	Potential failure mode	Provider orientation does not include introduction to type of facility and background, mission and values	Provider orientation does not include documentation and coding training	Provider orientation does not include EHR workflow training
	3	Potential cause(s)	HR not educated in organizational history and structure	Organization not aware of documentation issue or importance; does not conduct audits or have coders on staff	Multispecialty practices are too hard to standardize EHR workflows
	4	Severity	4	7	8
	5	Probability	8	7	7
	6	Hazard score	32	49	56
	7	Action (eliminate, control, or accept)	Control	Control	Control
	8	Description of action	Share policies, mission, values in training.	Develop plan and process for training on documentation and coding.	Develop EHR/scribe training program

Table C3

Process step #3	1	Process step	Provider training		
	2	Potential failure mode	Provider training does not include review of organization, state and federal regulatory documentation requirements.	No EHR training department	No EHR superuser(s)
	3	Potential cause(s)	Too complicated to stay current with industry guidelines.	Not in the budget; takes time to develop and create, outdated by the time it gets off the ground.	The position(s) are hard to fill, not enough resources.
	4	Severity	8	8	6
	5	Probability	9	7	6
	6	Hazard score	72	56	36
	7	Action (eliminate, control, or accept)	Eliminate	Eliminate	Eliminate
	8	Description of action	As part of provider orientation share organization background, mission and values. In addition, share basic requirements organization must adhere to.	Create budget and develop auditing and documentation department to partner with EHR trainers on workflow.	Promote EHR champions to EHR superusers to assist providers/scribes and medical staff on proper workflows for services rendered within scope of practice.

Table C4

Process step #4	1	Process step	Provider begins to see patients.		
	2	Potential failure mode	Scribes not trained on proper documentation practices.	Documentation does not meet medical necessity for services rendered; missing or incomplete medical records.	Lack of provider support.
	3	Potential cause(s)	Completed some college classes but not specific to coding and documentation.	Providers are rushed to meet productivity standards; system does not adhere to current clinical practices.	Organization does not have enough manpower to better support providers.
	4	Severity	7	8	7
	5	Probability	9	8	7
	6	Hazard score	63	64	49
	7	Action (eliminate, control, or accept)	Eliminate	Control	Control
	8	Description of action	Create training program that includes scribes and medical staff.	Create training program designed by both clinical documentation improvement specialists/experts and EHR superusers.	Create an environment that better supports and trains providers before they begin seeing patients.

Table C5

Process step #5	1	Process step	Audits conducted		
	2	Potential failure mode	Audits are not conducted.	Audit sample size is too small and not enough to identify gaps in training.	Feedback is not provided to providers.
	3	Potential cause(s)	Process is not in the budget; organization unaware of potential risks.	Auditing team is too small to audit all providers and/or not enough time to audit multiple times a year.	Due to fear of upsetting providers and them quitting; constructive feedback is limited.
	4	Severity	8	7	7
	5	Probability	7	6	7
	6	Hazard score	56	42	49
	7	Action (eliminate, control, or accept)	Eliminate	Control	Eliminate
	8	Description of action	Conducts audits whether done internally or hire externally.	Ensure sample size represents the organization's work. If too small, results may be skewed.	It is unfair and disservice to the provider – create a safe environment for education and opportunity.