EHRs: Improve Data Accuracy to Avoid Compliance Pitfalls

Whether you are working with electronic health records (EHRs) or paper charts, accurate data entry is essential for good patient care. In addition, the integrity of these data is mandatory for meeting federal compliance requirements. Although electronic records can substantially improve documentation accuracy compared with paper charts, it is also easy to inadvertently create errors that may then be repeated throughout a patient's record.

Here are some common mistakes that can lead to erroneous entries in an EHR system—and what you can do to avoid them and improve compliance and data integrity.

Avoid EHR Pitfalls

Fine-tune preference lists. Drop-down menus of commonly prescribed medications or frequently used diagnoses help facilitate completion of the record. Although these preference lists can expedite a patient encounter, they can also pose problems. Mistakes may occur if you choose quickly from the list without verifying your entry.

For example, said Michele Lim, MD, at the University of California, Davis, Eye Center, "We frequently order the antibiotic eyedrop ofloxacin, which is a medication that is also routinely prescribed for ear infections. The way our drop-down list was created, ofloxacin eardrops come first, which increases the likelihood of selecting the incorrect medication."

To avoid confusion, she recommends that you logically organize your system's preference lists and drop-down menus, putting the most commonly used medications at the top of the list and excluding unnecessary items.

Use care when copying data. The ability to copy patient data forward from a previous encounter to the current exam can save time. David Silverstone, MD, at the Yale School of Medicine, said, "It is a handy tool because when you copy something forward and then modify it, 1) you do not have to re-create the entire description, and 2) you are reminded of everything you previously observed." Although this makes it less likely that you'll overlook something important, he noted that this feature should be used with caution.

Modify templates as needed. Similar concerns were expressed by AAOE EHR committee chair Joy Woodke, COE, OCS, at Oregon Eye Consultants, in Eugene. It can be so effortless to navigate an EHR's built-in templates that there may be a tendency to copy information without thoroughly reviewing it and verifying the accuracy. As a result, potential medical issues may be missed.

"One way to avoid this pitfall is to design the templates in a way that prompts users to verify information before it can be saved," she said. For example, rather than simply being copied forward, the prior information could be displayed, but the user would be required to enter it or check off boxes to confirm it. She suggested modifying templates to include an extra step to help ensure that the data being documented for the encounter are current.

Don't let the template tell the whole story. EHRs offer various ways to import information within templates. A typical example is a brief boilerplate paragraph summarizing topics commonly discussed with patients. Some are more detailed than others (e.g., consent for cataract surgery), and they may contain elements that were not actually performed during a specific encounter.

"When we first embarked on EHR use, we all thought that documentation would be so much better and faster because we can import these templates," said Dr. Lim. But now she advises clinicians that "typing out one free-text sentence of what actually occurred, and was discussed with a patient, is worth an entire paragraph of a beautifully written template that includes information that did not really happen." She emphasized the importance of careful editing when using templates that include prewritten text.

Document what was done. Leaving out key details of an encounter results in an incomplete record. Nonetheless, said Dr. Silverstone, "It is easy to inadvertently omit a vital piece of information when conducting an exam because you are often multitasking." When you later look back at the record, you know

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that a particular task was performed because it is an integral part of your regular routine, he said. But if it was not actually documented in the record, you cannot prove it. Such an omission "can potentially pose a multitude of problems with patient care, billing, meeting compliance requirements, and possible litigation," he said.

Dr. Silverstone related a recent experience: "I was scheduled to operate on a woman who had just been seen by her internist for a thorough preoperative physical." According to the patient, the internist had listened to her heart and lungs. "However, this information was not documented in her record, so it had to be repeated prior to surgery."

Ms. Woodke said, "Whether you are conducting an exam, responding to a patient's phone call, or consulting with another physician, all the pertinent information should be recorded during a patient encounter and reviewed before the record is signed by the physician." She warned that if something doesn't appear in the chart, the auditors will presume that it hasn't been done.

But beware of overdocumentation. On the other hand, EHRs are so efficient and thorough that it may be tempting to populate every single field within your template. Before doing so, said Ms. Woodke, ask yourself, "Is it medically necessary today, in this exam, to document all of these fields?" She added, "Embrace the functionality, but always provide checks and balances. Most importantly, always keep in mind what is medically necessary. If these elements are met, we should feel comfortable that we are not over- or undercoding and that our documentation is accurate."

Be Proactive

Conduct regular internal audits and train your staff. Every practice, no matter the size, should have a compliance protocol in place and should also conduct periodic internal audits to identify errors within its records. Ms. Woodke recommended performing quarterly audits, which are followed by staff education and training.

"There are reports that you can run to identify missing data. These quality control measures should be constantly monitored so you can quickly detect any anomalies. Any time you see a change in documentation, it should be an immediate cue for a review." She also suggested regularly reviewing—weekly or monthly—chart documentation procedures and compliance requirements with staff.

"Practices should also provide education and training to end users when specific problems arise or when new services are offered, or for unique cases that are not frequently documented. Consistently accurate documentation all boils down to good training and education for every person who touches the system," she said.

Maintain a compliance folder. Everyone makes mistakes. It is important to note, however, that a mistake is much different from intentional fraud. Ms. Woodke said, "We want to ensure that anyone auditing our charts can quickly differentiate the two.

"One way to do that is to implement clinical protocols that document how our chart records should and should not be recorded. Education and training should also be recorded so that when an error is identified, you can instantly prove how and when training occurred." All of this goes into a compliance folder that provides your practice with another layer of protection, she said. "The more that we document our policies, procedures, and education, the more we are protected."

Best Practices for Data Integrity in EHRs[1]

- Learn your EHR system.
- Establish rules and policies for entering data into a medical record.
- Ensure that the EHR has an auditing function to monitor who enters and modifies data.
- Document what you do and only what you do. The note should reflect your thought processes.
- Use shortcuts carefully. Review and edit final notes.
- Never copy from one patient's chart to another.
- Avoid including data that are irrelevant to the current exam, especially notes created during previous encounters with the patient.
- At the end of an exam, review the data, sign the note, and lock the note so changes cannot be made by others.

1 Silverstone DE et al. Electronic Health Records: Compliance and Medicolegal Issues. Presented at: AAO 2017; Nov. 12, 2017; Las Vegas.

Dr. Lim is professor of ophthalmology, vice chair, and medical director at University of California, Davis Eye Center. **Dr. Silverstone** is a clinical professor of ophthalmology at Yale Medical School, in New Haven, Conn. **Ms. Woodke** is the administrator at Oregon Eye Consultants in Eugene. *Financial disclosures: None.*