PHYSICIAN DOCUMENTATION: MY, HOW TIMES HAVE CHANGED!

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Anyone who has been a part of the medical field for more than a few years can attest to the multiple significant changes that have occurred. Starting my nursing career forty years ago, we did a lot of handwashing but did not wear gloves except for sterile procedures. Now, a nurse wears gloves to take your temperature. Twenty years ago when I began my coding auditor career, I often felt like a hostage in the medical records department, typically in the basement of the hospital, wrestling ten-pound charts, searching for the subsequent hospital note where a physician had handwritten in typical physician penmanship.

As you can imagine, my life as an auditor has significantly improved as I sit at my computer in my office and remotely log in to the hospital medical records to review those subsequent hospital notes. Because it involves protected health information, the paperwork to grant access often rivals closing papers for buying a house, but eventually I'm given remote login access, and the process is a breeze. Further, very few hospitals or offices have handwritten notes, so all records are legible. That's a win-win!

On the other hand, I've observed a costly downside. I often see physician frustration and sometimes resignation when it comes to the good news/bad news of having an electronic medical record (EMR). While on one hand, notes are accessible from anywhere, multiple physician entries can be gathered in one place, and notes are always legible, there is another often overlooked perspective. The introduction of EMR has added a layer of work for the physicians that did not exist with paper charting. The most often-heard complaints: the template makes it hard to document the details of the patient's condition, the exam doesn't accurately reflect what I'm doing, and there are static template issues that make it difficult to indicate clearly the assessment and plan. They are embarrassed by creating a six-page EMR note filled with defaulted information that another physician can't understand. Add to these frustrations the need to track data for meaningful use, PQRS, quality, and other data mining and you can see why the typical physician who went to medical school solely because he or she wanted to take care of sick people is overwhelmed.

What is a Practice to do? Since EMR is here to stay and has been mandated by the government, there is no going back. But Practices can do a few things to help with the transition. First, the process needs to be realistically presented to the physicians without the sales pitch used to sell the system. Tell them it will be labor intensive initially; no, it won't save time documenting; but, it will save time looking for lost charts. Provide them the resources needed to customize the notes as much as possible while keeping them coding compliant. Don't buy into the promise that coding will no longer be the responsibility of the physician, and the computer will correctly select the codes. Interestingly, I can often tell when a Practice is using the EMR code calculator because the majority of codes selected are *lower* than the

documentation supports, thereby costing the Practice revenue, and, in some compensation models, lost wages to the physician. Be sure the physicians have adequate support until they feel comfortable with the EMR. In some cases, consider hiring scribes for older less tech savvy physicians who continue to struggle.

The bottom line is this: the physician is the backbone of the Practice and needs to not only be efficient with the EMR but also needs to feel they are still able to do what they are trained to do--take care of the patient. Be sure they know you understand the frustration and are willing to do what is needed to make the process as easy for them as possible. A little consideration goes a long way!

For more information about Coker's coding and compliance and/or chart audit services, contact Jeannie Cagle, RN, BSN, CPC, Senior Manager at jcagle@cokergroup.com or by calling 678-773-5146.