

FAQ on Documenting in Electronic Health Records

Accessing Information in Other Health Records

Q. How can I quickly refer to information documented in other parts of the health record without copying the information into my new record?

A. There are many circumstances when it is appropriate to include information from other parts of the health record (including notes written by other providers) in a current note. To reference that information without repeating it, you may simply confirm or supplement the information previously documented and refer to it by author and date.

Examples:

- “The patient’s review of systems, past, family and social history are unchanged from the Dr. Smith’s admission note of 5/15/2010 except that the patient is now complaining of much more pain.”
- “Lumbar spine MRIs from 1/20/09 and 2/17/10 show no progression of the disease per Dr. Robert’s interpretation.”
- “Physical exam is unchanged from patient’s 10/18/09 visit except that blood pressure is now 132/84 and open wound on left heel is now completely healed, although still tender to palpation.”

Q. One of the great things about an electronic record is that you can easily copy forward information from previous notes or pull in other data from the medical record without having to rewrite everything. Are you telling me that it’s inappropriate to use that functionality?

A. No. You can use the copy and paste or copy forward functions that are available to you. However, practitioners should use caution when copying or pulling forward text from previous encounters, especially with information that is likely to change as the patient’s clinical status evolves. For example, the “impression” and “plan” portions of E/M documentation are likely to change with each encounter and should not be copied forward without editing. And in all circumstances, the practitioner copying or pulling forward information is responsible for the accuracy of that information to the specific service the practitioner is providing.

Q. I’ve seen notes where the entire inpatient record for a single specialty is copied forward each day and changes are made as dated entries to the beginning and/or end of the comprehensive record. What do you think of using that technique for documenting?

A. When a great deal of outdated or needless text is carried forward encounter after encounter the value of the record is reduced. Practitioners may not take the time to read through exceptionally long documents for any valuable information that might be stored there. Also, from a billing standpoint, carrying forward outdated information tends to erode the credibility of the final document. We do not recommend this method of documenting patient encounters.

Templates and Macros

Q. I keep trying to get the right documentation into the record but it seems like I’m always missing some “key” word. Can’t you help me with that?

- A. Both ORCA and Epicare and many other documentation systems allow you to create templates and macros that you may use rather than trying to remember the correct wording each time you create a note. You can also create autotext (in ORCA) and smart phrases (in Epicare) which are macros that can automatically apply frequently used statements or phrases as a shortcut to quickly documenting required information.

However, it is important to remember that whenever templated information is used to record a patient encounter, the template should be modified to reflect the actual patient work completed on this date. All options should be clarified and all details should be entered. For example, if a template states that a teaching physician was either “present for the entire procedure/present for the key and critical portions of the procedure and immediately available throughout”, the templated information should be edited to indicate the actual situation. That is, the practitioner should indicate whether he or she was present for the entire procedure or present for the key and critical portions of the procedure.

- Q. What about the functionality that allows you to pull the results of diagnostic studies into your record? You can even set up your templates to automatically pull in that information so that you don’t have to remember to document it separately. Is this OK?
- A. Rather than making it a habit to have lots of diagnostic results default into your note, consider referring to the records that already exist elsewhere in the medical record. Only those results that are especially important to the encounter you are describing should be repeated in your own note.

What Does This Mean?

- Q. When I am asked to “authenticate” my note, what are they expecting me to do beyond just signing it?
- A. Authentication of your records, although often done with a signature, is actually an assurance that the record is accurate and complete. Before you authenticate any record you should carefully review all of the information from start to finish. Any inconsistencies or outright errors can be corrected at that time. This is also the time you can review your record to make sure that it is readable and easily understood. The final authenticated record should fully describe the service that was performed, including the reason the service was needed.
- Q. Can we use abbreviations in our notes?
- A. Yes. Standard abbreviations that can reasonably be expected to be understood by trained personnel may be used. Be careful to avoid non-standard abbreviations or abbreviations that might be easily misunderstood. Both UWMC and HMC have policies on use of abbreviations in the medical record.

Whose Documentation Can I Link To

- Q. Can I reference documentation created by the ARNP who works in our clinic? I think she is employed by the facility.
- A. Yes, you can reference that documentation as long as you have redone the work and attest to the fact that you have done so. For example “I confirmed that the ROS documented by ARNP Jones on 6/4/10 is unchanged during today’s visit.” It is critical that you document

that you personally re-performed the work associated with that previous documentation and also record that the information is still correct or how it is changed at the current visit.

Students

- Q.** We've been told that we cannot link to the notes written by the students who are working with us. Is that correct? How do students get the experience they need in writing appropriate patient records?
- A.** Students (medical students, PT students, PA students, nursing students, etc.) are not licensed to provide healthcare services. The only aspect of the service documented in a student note which can be linked to for billing purposes are the ROS, PFSH and taking the patient's vital signs. Students can document any aspect of patient care in the chart, including the history, exam, and medical decision making; however, this documentation cannot be used to support billing as the students are not licensed providers. If a student has documented services that represent work performed by a physician, those services must be re-documented to be billable.