



**Statement Attributable to
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American Medical Association
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Opening

Good Morning. My name is Steven Stack and I am an emergency physician from Lexington, Kentucky, and the Chairman of the American Medical Association.

On behalf of the AMA, I am pleased to be here to discuss the impact of electronic health records on clinical documentation, coding and billing.

The AMA believes that health IT and health information exchange, done well, are essential to our efforts to advance the triple aim – better health, better care, and lower costs.

That we are here today is testament both to the successes and shortcomings of the Meaningful Use Program.

In the positive, Meaningful Use has spurred rapid adoption of health IT. Without the incentives provided and collaborations fostered by this program, it is unlikely our health system would be adopting these necessary tools as rapidly as it is now.

There have also been undesired consequences. Attempting to transform the entire health system in such a rapid and proscriptive manner has compelled providers to purchase tools not yet optimized to the end-user's needs and that often impede, rather than enable, efficient clinical care.

For these reasons, and as a general observation, the AMA is grateful that Stage 3 rulemaking has been postponed to allow health care providers and EHR vendors much needed time to work together to address these shortcomings. Additionally, we believe that more flexibility is needed for providers to meet Stage 2 Meaningful Use requirements in order to better accommodate the diversity of clinical settings and variation in workflows.

Other presenters today are discussing the impacts of the increasing prevalence of disease, the rapid evolution in new technologies, and interventions that enable us to help patients now far more than ever before. Hoping to compliment rather than

reiterate their points, I have chosen to share perspectives on how physicians document clinical encounters, the impact of EHRs on this documentation, and common frustrations associated with the EHRs.

Physicians, Technology, and EHRs

To begin, I note that physicians are prolific technology adopters. They quickly incorporate and make use of all sorts of new patient monitoring devices, diagnostic imaging equipment, advanced surgical tools, and innovative medications. Incentive programs and mandates have not been necessary for physicians to voluntarily embrace these technologies that have improved their patient care and efficiency.

EHRs, however, are unique in that they have required a dedicated federal stimulus program to compel their uptake by the healthcare community at large. This has been necessary, in no small part, because they are still at an immature stage of development. EHRs have been and largely remain clunky, confusing, and complex. Though an 18 month-old child can operate an iPhone, physicians with 7 to 10 years of post-collegiate education are brought to their knees by their EHRs.

When an EHR is deployed in a doctor's office or hospital, physician productivity predictably, consistently and markedly declines. Even after months of use, many physicians are unable to return to their pre-EHR level of productivity – there is a sustained negative impact resulting in the physician spending more time on clerical tasks related to the EHR and less time directly caring for patients. In a way, it ensures the physician practices at the bottom of his degree.

It is no surprise, then, that a recent survey by American EHR Partners demonstrates continued escalation in physician dissatisfaction with their EHRs. In fact, between 2010 to 2012, the percentage of doctors who would not recommend their EHR to a colleague increased from 24% to 39% and approximately 1/3rd of all surveyed said they were “very dissatisfied” with their EHR and that it is becoming more difficult to return to pre-EHR productivity levels.

Simply stated, many EHRs are not friendly to the user and rather than improving physician efficiency, they are a widespread source of frustration. Clinical documentation, though only one facet of the problem, is an illustrative example.

Clinical Documentation

In the now distant past, the medical record was primarily a tool used by physicians to record their findings and decision-making process for their personal future reference and as a communication tool with other physicians. An ideal note for a physician's needs might read like this:

- 24 y/o healthy male. Slipped on ice and landed on right hand. Closed, angulated distal radius fracture. No other injuries. Splint now and to O.R. in a.m. for ORIF.
- 18 y/o healthy female. Fever and exudative pharyngitis for 2 days. Exam otherwise unremarkable. Strep test +. Rx. Amoxil

These notes are brief, direct, and lack superfluous detail.

Over time, however, the medical record has become progressively more a tool for coding, billing, compensation, compliance, and litigation. In particular, to fulfill the requirements of private and government payers, a detailed evaluation and management (E/M) documentation paradigm was created in 1995 as a means to translate the cognitive work performed by a physician into a standardized collection of data to assign economic value to the service provided. These E/M guidelines, despite acknowledged limitations and multiple efforts to revise them, remain in use today as the principle means of documenting and compensating for individually performed physician work.

Before EHRs, physicians commonly hand-wrote or dictated their notes. They relied upon their own memory plus various assistive tools such as reference cards, standardized forms, and other clinical staff to help them to comply with the E/M guidelines. It took time to document properly but each chart looked unique and the content largely had to be created from scratch. Widespread adoption of EHRs, however, in combination with a progressive shift towards team-based care is again rapidly and dramatically changing clinician documentation.

EHR Impact on Clinical Documentation

Documenting a full clinical encounter in an EHR, from scratch and a single data point at a time can be pure torment. The full chart doesn't fit on the computer screen. Each element is selected by a series of clicks, double clicks, or even triple clicks of a mouse button. Standardized language, not necessarily intuitive or ideal, is presented for all items being documented. Hunting, clicking, and scrolling just to complete a simple history and physical exam is a tedious and time-wasting experience. Typing free-text, while more individualized, takes additional time and introduces unstructured data that creates additional issues.

To address these glaring inefficiencies, various shortcuts and tools are used in the EHR. The most common of these are templates, macros, and cut & paste. None of these are inherently bad but each of them can be misapplied, accidentally or intentionally.

Templates are pre-formatted portions of a chart. For a physical exam, for instance, there may be a list of 12 organ systems each with specific terminology presented

within each organ to describe normal or abnormal findings. All the words are already on the page, but nothing has yet been documented. The physician then checks boxes, circles words, or slashes through words to indicate the presence or absence of each discrete item. This is usually done through mouse clicks and scrolling up and down a long list of items on a computer screen. As long as the physician documents only those things he actually did and documents accurately this results in an accurate, though very homogenous-looking, physical exam record. Additionally, templates can prompt or remind physicians to check or do things they might otherwise have forgotten to do and, in this manner, can provide some degree of clinical decision support. Unfortunately, selecting every single item individually takes a fairly long time so a second documentation tool is often used to streamline this process.

A **macro** is essentially a completed template with answers previously determined and automatically entered. For the sake of example, imagine that a physician has a basic and a comprehensive examination with specified elements that she does each and every time she does that type of exam. In this scenario, she may pre-enter the findings for both a normal basic exam and a normal comprehensive exam and save these in a similarly named macro. Now, each time she performs one of these exams and finds it to be normal, rather than re-creating the entire exam from scratch, she can select and import her normal macro for the relevant examination and the EHR will automatically populate the exam based on her previously entered selections. Again, as with the use of the blank template, as long as she has actually performed the work documented, the use of this macro is an efficient and effective means to streamline the data entry process. Additionally, if there are minor variations, she can import the macro and then only alter those data points that differ for a specific patient.

Macros can be a problem, however, when a physician either through innocent human oversight or active intent, imports a macro containing information he did not actually verify. In this instance, extra care and attention is required because the technology tool can make it alarmingly easy to accidentally introduce inaccurate information into the medical record.

Cut & paste, carry forward, and importing are differing ways to describe a third concept that arises uniquely with EHR documentation. In this instance, the clinician reuses information previously documented. For static information, this is a logical and beneficial use of the EHR. If Mrs. Jones had her appendix removed in 1977 that data will not change for the rest of her life. Additionally, if she learned that she was allergic to penicillin in 1977 when she had that appendectomy, that information will also follow her for the rest of her life. So long as these items are accurate, it makes good sense to carry them forward through the electronic record so every clinician has this information. There is no value added by a clinician re-asking all these questions and, in fact, there is risk that the patient or physician will overlook some important historical data and an otherwise avoidable error could occur.

Cut & paste becomes bad and is appropriately criticized as “**cloning**” when clinicians reproduce information created by themselves or others either without attribution or without attention to its accuracy. It is not appropriate for a clinician to copy another professional’s history, verbatim, and present it as if he had obtained it from the patient himself. It is often appropriate, however, for a clinician to document that she has reviewed the note of another professional and to summarize the key elements in her own note with attribution to its source. Making use of another example, errors in charting remain errors in charting whether done in an EHR or on paper. Regardless of the frustrations associated with the EHRs, physicians and other clinicians still have the obligation to review their own documentation to ensure that the information is accurate. EHRs can make this process infuriatingly difficult at times. Even so, though it is may not be fraud, glaring inaccuracies created by carrying forward prior notes with obvious errors are simply not acceptable.

All three of the above concepts, i.e. templates, macros, and cut & paste, create another peril for physicians. In large measure, every clinician using the same EHR will create charts that look remarkably similar to every other clinician using that same EHR system. Many in payer and compliance communities have long bemoaned the inconsistencies and variation in physician documentation. Now, EHRs have shifted the criticism to one of overwhelming homogeny. Even if the clinician accurately selects the individual data points on a template, every single chart containing that documentation template will look essentially the same and make use of the exact same words. In this case, it looks as though every clinician has plagiarized the words of every other clinician.

In fact, many large EHRs enable users to access the templates and macros created by any user in the system. If one physician has a particularly pithy, erudite, or precise way of describing a certain finding or condition and saves it as a “favorite,” she may later find that her own words begin to appear in the notes created by other clinicians who liked her description so much they adopted it themselves. Imitation is, after all, the sincerest form of flattery! Again, as long as the description accurately describes the work done by the physician and the condition of the patient they are treating, this is not fraud but it certainly is “cloning.” Since we are not talking about a college thesis, the concept of plagiarism is moot but we are still left with lots of clinical charts that all look remarkably alike.

Alarming, some Medicare carriers have already disseminated rules that if charts look too much alike they will deny payment for them. In this instance, even when clinicians are appropriately using the EHR, a tool with which they are frustrated and the use of which the federal government has mandated under threat of financial penalty, they are now being accused of inappropriate behavior, being economically penalized, and being instructed ‘de facto’ to re-engineer non-value-added variation into their clinical notes. This is an appalling Catch-22 for physicians.

Additional Considerations

I would be remiss if I didn't also mention some of the other challenges associated with the impact of EHRs on clinical documentation, coding, and billing:

- Government and private payers are requiring more and more specific data, quality reporting elements, and specialized reporting be collected in the EHR. Capturing and entering all this data takes time and can elevate the intensity of service.
- Because so many people and so many devices collect so much information, the medical record is becoming so large and unwieldy as to be indecipherable. Simple patient encounters now routinely generate scores of pages of documentation and can be nearly impossible to identify the truly important data amidst all the clutter.
- Vendors create standardized, stock EHR products for their clients. Attempting to change these standardized products is either refused, resisted or comes at substantial expense. As a result, most clinicians are compelled to make use of whatever they have been provided. The physicians know there are problems but are powerless to fix them.
- Because every entry is timed and all entries and orders endure in the EHR, it can be nearly impossible to actually understand what really happened and why. Canceled orders show up along with executed orders. If an order is entered incorrectly, canceled, and re-entered correctly, there are 3 separate orders displayed for all these actions rather than simply what was finally done for the patient.
- Temporal, or time-based, charting also creates a confusing morass of documentation that gives a false impression of how the care and work was actually done. I won't explore this topic at length today, but some very bizarre descriptions of EHR "time-warp" have been elsewhere described.

In light of all these challenges, it is even more unsettling that ONC recently announced that it has revoked the certification of two EHR systems and said that providers cannot use those EHRs to satisfy meaningful use requirements. What about the providers who already purchased those certified systems? What protection is this for them? Will ONC reimburse them the cost of their previously certified, now de-certified EHR? This sort of peril to providers and individual clinicians who otherwise followed all the rules they were given is horribly unfair.

My purpose in giving these examples is not denigrate EHRs. I reiterate that the AMA and most physicians believe that, done well, EHRs have the potential to improve patient care. At present, however, these EHRs present substantial challenges to the physicians and other clinicians now required to use them. Under these circumstances, it is certainly not reasonable to be overly critical of physicians for struggling to comply with the inadequacies of mandated EHR adoption, particularly when the physician community has vocally and repeatedly raised many of these concerns from the very start.

Conclusion

The AMA offers the following suggestions to address the concerns identified above:

- **ONC should immediately address EHR usability concerns raised by physicians and take prompt action to add usability criteria to the EHR certification process.**
- **CMS should provide clear and direct guidance to physicians concerning the permissible use of EHR clinical documentation for the purposes of coding and billing. Given the examples described above, the creation of this guidance clearly requires active dialogue with the physician community so as not to further hinder patient care or further erode physician productivity.**
- **Stage 2 of the Meaningful Use program should be reconsidered to allow more flexibility to providers to meet these requirements while the EHRs are better adapted to accommodate the diversity of clinical settings and appropriate variation in workflows.**

I again thank you for taking the time to carefully consider the impact of EHRs on clinical documentation, coding and billing.

On behalf of the AMA, we look forward to working with you to realize the full potential of EHRs to advance the triple aim of better health, better care, and lower cost.