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Things I Have Learned: The Trouble with Computerized Records

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The current trend in healthcare is electronic record-keeping. At this time you can find over a dozen different software programs to help you generate or keep patient records. I have written many times in this column about the importance of keeping clear and accurate records. I will be the first to admit that all that paperwork is a pain, but it is nonetheless vitally important to maintain clear, concise, contemporaneous records of your patient care. Many of the electronic health record programs out there tout "quick and easy" recording of patient information – but is "quick and easy" the same as "accurate and appropriate?"

Certainly any amount of record keeping is a pain, it just takes time away from what we love to do - taking care of patients. But like it or not, we have to have records of the patient's complaints, objective findings, treatments rendered, and the future care plan. Any tool that makes that job easier should be investigated.

The great concern is that many of these programs have random vocabulary generators to "fill in" verbiage. This is often a very big problem. It is great that you can plug in a few pain score numbers, or scan in a few bar codes for procedures to generate data, but the report process should not stop there. I have seen many cases where the practitioner uses a program to generate many pages of patient data, only to have that data become suspect because the narrative generated was either not sensible or suggested other findings.

It is probably best to show by example. The following is an example of unedited computer

generated verbiage I have encountered in the orthopedic examination section of a report:

"Positive Palpation Muscle Spasm Cervical Positive Palpation Muscle Spasm Thoracic Positive Palpation Muscle Spasm Lumbar Distraction Positive Lumbar Kemps Positive Thoracic Lesque Positive Lumbar." – that's it. No explanation, no punctuation, not even proper spelling. Notations like this cannot be taken seriously and only serve to question the credibility of the practitioner.

The next issue often seen with electronic health records is treatment options listed in "check off" format. It becomes impossible to interpret care when presented with a phrase such as: "Treatments rendered today may include: needle treatment, hot packs, cold packs, spinal tuina, electric muscle stimulation, ultrasound, rehabilitation exercise, massage, fomentation, laser stimulation, and neuromuscular reeducation."

Not only is it unrealistic and unreasonable to provide that many therapies on a given visit – it suggests that the provider has no organized or coherent care plan. Make sure the records generated accurately show the specific treatments provided on that date of service.

Another problem with computer note programs is "roll over" data. If data, such as pain scores, is entered on a visit future scores are compared and automatically notated. For example, if a patient's lower back pain was "acute" at an 8/10 on one visit, and the next visit the pain was down to 6/10, the change should well be noted as "improved." But if the pain score does not change, or goes up and down, the vocabulary generator may very well state: "Patient reports no improvement in their pain complaint." If the practitioner does not go in and clarify such comments, the records end up stating that the care provided did not help, or made the patient worse.

This is especially significant with programs where you enter data for many dates of service over a period of time. If the patient hits a plateau or has a flare up often the program can state that your patient was worse with treatment. Just entering values and generating a report is not good practice – make sure you review the generated vocabulary to accurately describe the patient's condition on a given visit.

Electronic health records are a great tool, but they are not an absolute. They may help you organize and collate your treatment data, but it is the responsibility of the practitioner to review these notes and make sure they accurately delineate the findings and care provided.

There is a standard of care in this country that is clearly defined. It is dangerous to think that because we are acupuncturists we do not need to keep records to the same degree as other healthcare practitioners. We must learn to think outside our own practice bubble and in terms of healthcare in general. Ultimately, it is the patient that we take care of, not the insurance companies, attorneys or the family doctor. Whether or not you feel obligated to document your case, responsible patient care mandates it.

Acupuncture deserves every bit of respect that any other health profession does, but that respect comes with a level of responsibility. Yes, it is a pain and it takes more time, but like it or not, documentation paperwork is part of professional healthcare.

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