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Don't Blame the EMR!

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The Electronic Health Record: Ramifications for CAP Fellow Education and Patient Privacy

- Concerns raised on SPCAP listserve
- My journey from the olden days to Epic
- Disadvantages of paper medical records
- Advantages and disadvantages of an EMR
- Pitfalls of using an EMR
- It's all about the teaching and supervision

SPCAP Listserve Concerns

- Fellows act as though what is in the EMR is the "whole story"
- Meaningful interactions and "personal" information not documented
- It's just a checklist

It's a long, long trail

- 1970's – WPIC – Kupfer Detre System (KDS) of structured paper forms – checklists and brief narratives
- WPIC – revised for children, adolescents and families by Puig-Antich, Ryan, et al.
- Paper versions of structured forms – successively updated and revised at Emory and Children's Memorial Hospital
  - Initial evaluation form
  - Medication evaluation form
  - Medication Note
  - Medication Log
  - Discharge Summary
- 1995 or so - I abolished outpatient dictation at CMH due to time, expense, lateness in dictating, delays in transcription, multiple revisions

Children's Memorial Hospital Epic Implementation

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- Done in stages, intense developmental process for each clinical program – customized templates, encounter types
- Team of hospital clinicians and administrators plus hospital HIM staff and consultants from Epic for design, build, and training
- Consolidation of PICU previous electronic and paper records
- Outpatient programs sequentially, over 1-2 years, total
  - CAP 2008 was about in the middle of the sequence
- Inpatient done across all units (including CAP IPU) at the same time, in stages. CPOE the final stage of initial implementation
- Now all parts and programs of the hospital use the same EMR
- Ongoing upgrades, improvements, learning from experience

Our Epic Implementation

Customized templates for note types

- Designed by our multidisciplinary clinicians (with administrative and trainee input)
- Initial evaluation form based on our old paper form – checklists, dropdown menus, "wild cards," smart texts, plus short narratives – HPI, patient observation, biopsychosocial formulation (required).
- Epic medication record (replaced paper medication log)
- Medication evaluation form
- Medication note
- Therapy note

Our Epic Implementation

- The final step – IPU and PHP discharge summaries now typed using Epic template, instead of dictated
- Parts written by different disciplines easy to combine
- In Basket to monitor work to be done
- Easy to route to supervisor
- The end of dictation!

Our Epic Implementation Privacy

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- Initial implementation – CAP diagnoses, problem list, medications, and lab/imaging tests available to all services
- 2 years later (2011) – opened fully to other services – "If they can see it on a neurology patient, they should be able to see it on ours."
  - Our clinicians more skilled at discrete documentation
  - Families of pediatric patients just as complicated as in CAP
  - Need for viewing of encounters by other services – scheduled and failed appointments, telephone calls, planning in sessions, etc.
  - Secrecy preserves stigma
  - After 1 year, no problems and improved patient care and cross-specialty relationships
- Now includes affiliated community pediatrician practices

Using an EHR

- Entering information takes longer than bare-bones handwritten or dictated, but advantages are
  - Ease of retrieval
  - Templates for data to be gathered and recorded
  - Order sets
  - Accessible to multiple clinicians for collaborative care or coverage
  - Charting for IPU can be done away from nurses' station
  - Documentation can be read by supervisor at any location, if remote access

Paper vs EMR
Patient safety

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Paper

- The system never "goes down"
- Handwriting often illegible
- Dictations often long and disorganized
- Charts not easily available
- Filing of paper forms delayed and sometimes wrong or missing

EMR

- Booting can be slow
- System can go down
- Record available 24/7 to any clinician with access – anywhere in hospital or remotely via VPN
  - ER
  - On call
  - Multiple services or clinicians can share
  - Each specialty and location can see information from all others

Paper vs EMR
Patient safety

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Paper

- Quality of care evaluations laborious – done by hand
- Key parts may be missing – eg medication log not up to date
- Case transfers get lost
- Lab results hard to find

EMR

- Growth charts and VS
- CPOE
- Automated auditing
- Letters
- Telephone encounters
- SmartLinks can pull information from other parts of the record
- SmartPhrases – standard text
- Tracking of case transfers
- Access to test results

Paper vs EMR Privacy

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Paper

- Parent can request entire record
- Paper charts lying around or easily viewed without detection
- Sending information to school or PCP requires new document or sending inappropriate one

EMR

- Parent can request entire record
- Hacking
- Stolen laptops not encrypted
- Unauthorized viewing can be tracked
- Easy to create short document for school or PCP
- Epic staff messages

Dangers of EMR

- Copy and paste
  - Own notes
  - Other people's notes
  - Excessive test results that can be accessed directly in EMR
- Copy forward
- Use of templates without editing for each patient encounter
- Use of smart text without customizing
  - Eg boilerplate on informing patient and parent about medications – include only what was actually done in this session with this patient
  - "No SI/HI"
- "Treating the EMR instead of the patient"

It's all about teaching and supervision

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- Cohen and Henderson Developmental Practicum narratives
- Detailed intrapsychic and interpersonal dynamics do not belong in the medical record
  - Too long
  - Too speculative
  - Problematic if accessed by parent, patient, lawyer, etc.
- It is our job to be sure trainees get full information and incorporate it into the formulation and the development of treatment plan
- Diagnostic information is necessary, but not sufficient
- Our Model - CAP fellows have a substantial number of "full cases" – outpatient, inpatient, PHP – where they do the therapy, family work, contacts with school and other clinicians, in addition to diagnosis and medication

It's all about teaching and supervision - Fellow notes in EMR

- Legible
- Easily accessible for supervision – all on-call, outpatient, IPU, PHP notes easily routed to supervisor for review
- Easily tracked for completion and timeliness
- Final notes can be addended if necessary
- Draft notes can be "pended" for review prior to being final
- Dilemma – how obsessively supervisor should edit and correct
  - "Just the facts"
- Templates, checklists, and dropdowns remind trainees (and clinicians) of what should be asked and documented
- Current fellows more comfortable with typing and with using EMR during session than previous generations – important to educate them on not allowing EMR to interfere with forming and maintaining alliance

What contributes to "checklist thinking"?

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- Many fellows arrive from adult programs where they evaluate, medicate, and discharge large caseloads of patients with rapid turnaround and short lengths of stay. Even their required psychotherapy experience is often only one year. They have virtually no experience in talking with families or considering system dynamics and minimal longitudinal perspective.
- Multiple documentation requirements (paper or EMR)
  - Diagnosis
  - Joint Commission
  - Billing
    - New CPT codes
    - DRGs

What contributes to "checklist thinking"?

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- Faculty are busier and busier – not modeling comprehensive care or observing (live or recorded) fellow-patient/family interactions
- We have seen the problem for years in oral ABPN exams, but the elimination of these exams reduces fellow incentive to learn these skills
- It's in the culture – "Clinicians want shorter textbooks."

DISCUSSION

- Whatever the format, the medical record should be a tool for safe, efficient, and effective patient care and defense in case of lawsuit.
- Supervision is the place for teaching of formulation and dynamics
- How can we make sure that CAP fellows think comprehensively, and not just click to fill in the boxes?
- Concerns about EMR?