



EDITOR-IN-CHIEF

JOHN HICKNER, MD, MSc
 University of Illinois at Chicago

ASSOCIATE EDITORS

BERNARD EWIGMAN, MD, MSPH
 University of Chicago Pritzker School of Medicine

JOHN SAULTZ, MD
 Oregon Health and Science University, Portland
(Clinical Inquiries)

RICHARD P. USATINE, MD
 University of Texas Health Science Center
 at San Antonio *(Photo Rounds)*

ASSISTANT EDITORS

DOUG CAMPOS-OUTCALT, MD, MPA
 Mercy Care Plan, Phoenix

GARY N. FOX, MD
 St. Vincent Mercy Medical Center, Toledo,
 Ohio

RICK GUTHMANN, MD, MPH
 University of Illinois, Chicago

KEITH B. HOLTEN, MD
 Berger Health System, Circleville, Ohio

ROBERT B. KELLY, MD, MS
 Fairview Hospital, a Cleveland Clinic hospital

GARY KELSBERG, MD, FAAFP
 University of Washington, Renton

E. CHRIS VINCENT, MD
 University of Washington, Seattle

EDITORIAL BOARD

FREDERICK CHEN, MD, MPH
 University of Washington, Seattle

LARRY CULPEPPER, MD, MPH
 Boston University Medical Center, Mass

LINDA SPEER, MD
 University of Toledo, Ohio

THEODORE G. GANIATS, MD
 University of California—San Diego,
 La Jolla, Calif

JEFFREY T. KIRCHNER, DO, FAAFP, AAHIVS
 Lancaster General Hospital, Lancaster, Pa

FRED MISER, MD, MA
 The Ohio State University, Columbus

KEVIN PETERSON, MD, MPH
 University of Minnesota, St. Paul

GOUTHAM RAO, MD, MPA
 University of Chicago

JEFFREY R. UNGER, MD, ABFP, FACE
 Unger Primary Care Private Medicine, Rancho
 Cucamonga, Calif

BARBARA P. YAWN, MD, MSc
 Olmsted Medical Center, Rochester, Minn

DIRECT INQUIRIES TO:

Frontline Medical Communications
 7 Century Drive, Suite 302
 Parsippany, NJ 07054
 Telephone: (973) 206-3434
 Fax: (973) 206-9378

EHRs: Something's gotta give

As Chief of Family Medicine at our hospital, I have been spending a lot of time reviewing visit notes. The Joint Commission requires Ongoing Professional Performance Evaluations (OPPEs), which for family physicians includes quality of documentation of office visit notes. Judging quality, beyond the presence or absence of the usual suspects—history of present illness; pertinent medical, family, and social histories; physical exam; meds; problem list; assessment; and plan—is difficult because there are no standard, objective criteria. After reviewing many charts from several organizations, however, I'm concerned that 3 important elements of documentation are getting short shrift in our increasingly computerized and regulated environment: the history of present illness, the assessment, and the plan.

**I think today's
 EHRs are like an
 old-fashioned crank
 phone and what
 we really need is an
 iPhone.**

Clicking on a checklist of symptoms seldom provides sufficient information about the patient's illness. "Hypertension" and "type 2 diabetes" are not assessments; they are diagnoses that do not tell the person reading the electronic health record (EHR) how the patient is doing. A diagnosis of "abdominal pain" without a prioritized differential is inadequate, especially in court.

Why is visit documentation too often inadequate? I am convinced it is rarely due to clinician incompetence, laziness, or lack of knowledge, but nearly always due to a combination of inadequate EHR formats and billing documentation requirements that encourage quantity rather than quality. Documentation is no longer driven by the essential need to record the care provided.

I'm sure a lot of you are nodding your heads in agreement. You all know what those EHR notes look like—cluttered with cut-and-pasted information drawn from prior encounters that document no end of details regarding medical, family, and social histories, facts that are often completely irrelevant to the reason the patient is in the office today. And unless one meticulously updates those other elements of the patient's record, this information pulled into the note may be inaccurate.

I am not the only one complaining. The American Medical Association just published *Improving Care: Priorities to Improve Electronic Health Record Usability*,¹ which outlines 8 priorities for EHR improvement. The first is to "Enhance physicians' ability to provide high-quality patient care." I could not agree more. I think today's EHRs are like an old-fashioned crank phone and what we really need is an iPhone.

Something has gotta change.

So tell me: Have any of you figured out how to use your EHR to enhance the quality of your documentation?

1. American Medical Association. *Improving Care: Priorities to Improve Electronic Health Record Usability*. American Medical Association Web site. Available at: <https://download.ama-assn.org/resources/doc/ps2/x-pub/ehr-priorities.pdf>. Accessed September 18, 2014.

John Hickner
 jfp.eic@gmail.com