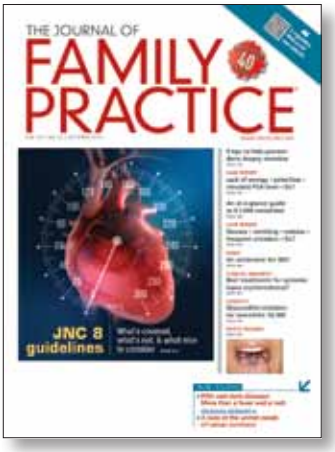
It takes work-arounds to make EHRs "work"



Dr. Hickner's editorial "EHRs: Something's gotta give" (*J Fam Pract.* 2014;63:558) prompted me to reflect on the elements of electronic health records (EHRs) that cannot change and the ones that can.

The EHR system I use allows the EHR to serve as a quality recorder, and it appears this is the most important part, because the reminders of what needs to be documented come first and are color-coded. From a reimbursement point of view, what is important is not the narrative, but the expanded "elements" that make it a billing document. I believe this will not change.

What can change is how the note information is organized, and I think the organization should be different for specific roles. At intake, a medical assistant can review allergies, medication lists, and preventive services; update family history; and take vital signs and history of present illness (HPI). As the physician, I want the note to show the information in the order that I process it during the visit: 1) allergies/medication list, 2) concerns/complaints with brief documentation, 3) vitals, 4) physical, 5) assessment, and 6) plan.

After the note is signed off on, I want a different format for review purposes: 1) assessment/plan (because this is what I look at first for follow-up), 2) HPI/review of systems, 3) physical, 4) allergies, 5) medication list, 6) past medical history, and 7) quality reminders (if they show up at all after the visit is complete).

Is it asking too much for a programmer to make the EHR organize information in this manner?

Edward Friedler, MD
Annandale, Va

I still dictate my notes and they very much tell a story that an EHR cannot. I have been audited repeatedly and I always have all the bullet points and essentials that the insurance company wants, but this information is in a format that everyone—including patients—can read and appreciate.

The move to APSO (assessment, plan, subjective, objective) from SOAP (subjective, objective, assessment, plan) is an example of the tail wagging the dog. Rather than fix the note so the time-honored SOAP format works, we acknowledge that no one actually reads the long template notes and they want to get to the bottom line (ie, the assessment and plan).

My dream is to return to the days when we only listed the positive findings, the assumption being that a competent physician did the exam that was required and it's unnecessary to state that the examined anatomy was normal. Unfortunately, so much of what we must do is driven by lawyers and insurance companies—not by doctors.

David M. Brill, DO
Rocky River, Ohio

I now take photos of all of the ludicrous choices our EHR tosses at me, such as "laceration of third eyelid" or "injury, crushed by falling aircraft due to terrorist." Most of my EHR entries now say, "See scanned handwritten note for accuracy."

The issue of EHRs needs to be kept on the front burner. It is destroying doctor/patient relationships and quality diagnostic care while hiding the important findings in the garbage.

Jay Hammett, MD
Knoxville, Tenn

I'm in a group practice of 10 family physicians and in a typical workday, each of us sees 23 to 25 patients, answers e-mails/phone calls, and reviews labs/studies, which leaves no time for anything else. There's a constant struggle to stay on top of the quality of the notes. I have preserved the quality of my own notes by free typing. I free type a differential next to my assessment or on the first line of the plan. I don't use templates; they slow me down too much.

Kelly Luba, DO
Phoenix, Ariz

EHRs are destroying doctor/patient relationships and quality diagnostic care while hiding the important findings in the garbage.

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ONLINE EXCLUSIVE

I was a civil service physician working for the Department of the Navy in 2005 when EHRs were thrust upon me. The system was not particularly user-friendly. Free texting was highly discouraged and it was strongly preferred that we used structured text embedded in the program.

I couldn't use the program as envisioned, so I found a work-around. I would paste the 4 sections of the SOAP note directly into the appropriate free text sections of the electronic record. My assessment included the correct diagnosis, and I would pick a general EHR diagnosis from the dropdown list. Visually, my records did not look any different from those of other health care providers who used structured text.

I used this method until my civil service retirement in 2014. All of my record peer reviews were outstanding, and I was told that my records were easy to understand. I finally let on to all that I never used structured text and that all of my records were really written the old-fashioned way. I still used a clipboard during the patient visit, and completed all records after the patient left.

David F. Scaccia, DO, MPH
Kittery, Maine

Health care reform coverage: Spot on or missing key options?

"Health care reform: Possibilities & opportunities for primary care" (*J Fam Pract*. 2014;63:298-304) was terrific. You nailed the opportunities and challenges with implementing advanced primary care.

Joseph Scherger, MD
La Quinta, Calif

Your article focuses on so-called "value-based" care and Affordable Care Act (ACA) options and ignores other forms of free market health care, such as concierge and direct primary care, that are growing in popularity with physicians and patients. When patients shop for and pursue self-paid care, they are invested in the process, participate in their own care, and have better outcomes. The free market will bring many diverse options to the table, increase the quality of care, and decrease the price of care to stay competitive.

Physicians must step up for their individual patients and be health care leaders, not followers of government mandates and insurance company policies. Patients deserve nothing less than a free-market, competitive environment, and a variety of care and insurance options—not just a few, as dictated by the ACA.

Craig M. Wax, DO
Mullica Hill, NJ

Authors' response:

We appreciate the comments of Drs. Scherger and Wax. We also agree that there is a move in some areas of the country toward direct primary care, as well as toward concierge medicine. However, it is our opinion that in their current form, these models are a symptom of today's health care system and not a solution.

The vast majority of Americans cannot afford to pay directly for their care. And since health care is not a free market system, free market reforms are not likely to be the solution for most Americans. However, if concierge medicine or direct primary care could be part of a menu of options through existing insurance, government, or employer models, the potential negative impact (including the exacerbation of the current strained primary care system) could be ameliorated.

We agree that physicians should always advocate on behalf of their patients, but we also believe we should think of *all* patients and how policy changes may impact society as a whole.

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