

EPAC Guidelines Promote Accurate Documentation in Epic **Document others as you would have them document you**

Many institutions that begin to use a new electronic medical record (EMR) for clinical documentation experience an initial deterioration in the quality of notes that is different from the quality issues before the advent of EMRs. In the past, short, incomplete and illegible documentations were the main issues related to quality documentation. Now, with the ability to import data automatically and copy-and-paste, the actual data in the notes are often incorrect.

The Office of Inspector General is investigating “cloning” of electronic medical records to weed out fraud and abuse in the Medicare program. Their reviews focus on multiple Evaluation/Management services for the same providers and will specifically examine medical records with identical documentation across services.

To address this concern, the Epic Physician Advisory Committee (EPAC) approved Documentation Guidelines to help clinicians create accurate notes within Epic. The guidelines include the following:

1. At least part of the Assessment and Plan (A/P) should be visible without scrolling
2. Avoid internal inconsistencies within the note
3. Change at least 3 words from yesterday's A/P
4. Clearly convey Thought Process in the A/P
5. Clearly convey Next Steps in the A/P
6. Clearly communicate the need for continued hospitalization or discharge plan in the A/P
7. Avoid blank or broken Smartlinks in your note
8. Keep lab results to less than 20 vertical lines of your note
9. Use proper attribution if you copy someone else's note
10. Avoid note bloat

Clear, complete documentation leads to good communication, which ensures the safety of all of our patients. Please adhere to these guidelines and remember the healthcare Golden Rule: **Document others as you would have them document you.**