Medical Records Issues

I am an imperfect human being, but honestly doing the best job I am able to do with the resources I have. Historically, I have viewed my records as a tool to manage care, not as a tool to defend it, and that has contributed to the Board's impression of me.

1. There are obviously issues with the way my medical records export. Among other glitches, I am the IT person for our practice and used the wrong field («CurrentMeds» instead of MedMgmt_CurrentMeds) in the template to export the notes, so that the actual current medication list, which we update at every visit, was not the one that was printed in the notes that went to the Medical Board. I recognized the issue when looking over those notes and have now corrected it. We explained this in a cover letter and offered to clarify if there were any questions, but it is not clear the reviewer was given that letter. I hope am a better doctor than computer technician. . . .

2. The reviewer actually missed the thread of my patients' stories, as for instance one of those five patients has tapered off opioids twice in my care, after being placed on high doses by other physicians for two different painful conditions. In the first condition I was able to diagnose the underlying problems that had caused it and thus to treat it successfully and decrease the need for opioids. The second condition also responded to treatment, allowing us to taper her opioids the second time.

3. I believe I use my medical record to track diagnostic studies, results of interventions, and needed follow-up very carefully, and to communicate sometimes complex treatment plans with my patients in real time. Ask any of my patients about the visit summaries they receive when they see me. There has been a definite learning curve, however, in how to keep medication lists accurate, make flow sheets work, etc.

4. What I do not seem to do well, however, is explain my reasoning and priorities to reviewers. It has always been my impression that no one but me will read most of my notes other than consultants at the time of referrals, so I have viewed the notes as a tracking tool, not as an explanation of care, which I see was an error, since I think as a Functional Medicine doctor, which may not make sense to others. In many cases, my care can best be tracked in the Recommendations field of the note, which is what prints out for patients so they have a copy of the plan in their hands as they leave the office. This is not where the reviewer was looking for that information.

As an example:
I carry forward old diagnoses under the subheading **Past/ongoing** in my assessment: If I do not address blood sugar issues on a particular visit, the language from the last time we addressed it will remain under that heading in my assessment until it is next addressed. I care for patients who may have 10 or 12 significant complex medical issues, some of which are only addressed once every 3-4 months or even once a year, and others which require monthly attention. I have witnessed medical lapses where providers forgot about something that needed follow-up at a year and feel that carrying this old information forward is a way to prevent those sorts of

mistakes, though apparently it can be quite irritating for someone who is reading my notes and only looking for my calculation of how much the medication is going to change in the next month. IT also may give the impression a problem like constipation persists when it has actually resolved.