HIDDEN LIABILITIES IN YOUR ELECTRONIC MEDICAL RECORD

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Future State: “Why don’t you use an EMR when the technology is known to prevent mistakes and improve the quality of medical care?”
HIDDEN LIABILITIES IN YOUR ELECTRONIC MEDICAL RECORD

Positives in Electronic Medical Record Use

- Documentation
  - May be more legible and complete than the typical free-form, paper-based record
  - Imaging, laboratory and other test data may be more readily available due to systems interfacing with EMR
  - EMR template(s) provide roadmap to documenting the
    - Interview
    - Physical Examination
    - Analysis of studies
    - Differential diagnosis
    - Final diagnosis
  - Computerized Order Entry (CPOE) may prevent drug errors
  - Diagnostic and referral results should be more easily tracked
  - Clinical decision support readily available to the provider

Say What? *#!
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Potential Pitfalls Arising From Electronic Medical Records

- Clinical documentation that is incomplete, inaccurate or untimely, due to:
  - Inadequate data governance practices resulting in data fragmentation or missing clinical information
  - Data in multiple locations
  - User workarounds to address system limitations/annoyances
  - Formal process for ‘locking’ EHR post visit and for addenda/corrections
    - Addenda are linked to the original created document;
    - Addenda must be authenticated in approved manner; and
    - Addenda must note be backdated.
  - Record retention schedule that takes into account regulatory requirements
- Data transmission/interface issues impacting completeness
- Templates that do not support the variety of patients and populations seen by the practice or contain too much information
  - Adult neurological exam template used for exam on 1 year old led one NJ jury to question accuracy of all exam findings
  - Boilerplate templates that generate paragraphs of data may result in critical findings not being adequately addressed

- Copy and Paste/Copy Forward/Cloning
  - Copy and Paste or Copy Forward can result in provider’s relying on previously recorded history, test results or clinical findings may:
    - Perpetuate prior errors and omissions
    - Result in failure to document new findings
    - Create documentation inconsistencies that result in billing errors and increased risk of litigation/malpractice liability
    - Expose practice to regulatory investigation risk for healthcare fraud

In some cases, physicians reported that template-based notes introduced enough false information to cast doubt on the medical record more broadly: ‘So here’s what’s happened with the EHR. I mean I get it, I understand it, but it has been a step backwards, I think—and as big a step backwards as it is forwards. The step backwards is the problem of templated information. … There’s templated information in the review of systems, (I think). ‘Really? You asked all those questions?’ Not really. Well, what percent? 80%… 70%… 60%… 30%… Did you ask any questions, really?’ —general surgeon

Evaluation and Management Services—Potentially Inappropriate Payments in 2010
We will determine the extent to which CMS made potentially inappropriate payments for E/M services in 2010 and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service on the basis of the content of the service and have documentation to support the level of service reported. (CMS’s Medicare Claims Processing Manual, Pub. No. 100-04, ch. 12, § 30.6.1.) (OEI; 04-10-00181; 04-10-00182; expected issue date: FY 2013; work in progress)

Additional Audit Activity
Meaningful Use Audits (Medicare and Medicaid)
Office of Civil Rights (Privacy and Security)
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Stakeholder Dissatisfaction

Study Findings

- Generally physicians approve of the concept behind EMR
  - Better ability to remotely access patient information for use in real time decision making
  - Potential to improve quality of care and patient and provider satisfaction

Caveat

- Current EMR technology does not support the promise
  - Poor Usability/Too Many Clicks
  - Time Consuming Data Entry
  - Interferes with face-to-face patient care
  - Inefficient
  - Poor ability to exchange information between HIT products
  - Degradation of clinical documentation
  - Cognitive and information overload

Possible Strategies To Address Stakeholder Dissatisfaction

- Ensure that work EMR supports practice workflows and are customized to the degree possible to support practice patterns of clinical staff/team
  - e.g. clinical decision alerts and medication defaults fit needs of practice
- Consider modes of data entry that decrease provider burden
  - Scribes
  - Dictation with human transcription
  - Dictation with machine enabled transcription such as Dragon (requires close attention to ensure accuracy of transcription)
- Ensure adequate training is provided for all users including physicians

Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy.
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Possible Strategies To Address Stakeholder Dissatisfaction

- Consider applying strategies borrowed from other industries to build in quality, remove the waste and increase practice stakeholder satisfaction including Patient and Family, (Physician(s), Non-physician Providers and Support Staff by ensuring that everyone is performing work at the top of their skill set, capability and within pertinent regulations.
- Minimize the total system waste and maximize the ability of the providers to add value to the patient (requires team work, job descriptions, policy and procedure) all with the goal of continually improving the quality of the patient experience, the patient ability to self-manage and the overall outcome.
- Engage everyone on the team in change management and identifying and eliminating waste.

HIDDEN LIABILITIES IN YOUR ELECTRONIC MEDICAL RECORD

E-Iatrogenesis

Iatrogenesis - inadvertent and preventable induction of disease or complications by the medical treatment or procedures of a physician or surgeon

http://www.merriam-webster.com/medical/iatrogenesis

E-Iatrogenesis - patient harm caused at least in part by the application of health information technology

“e-Iatrogenesis” - The Most Critical Unintended Consequence of CPOE and other HIT
Med Inform Assoc. 2007:14:387-388 (June 2007)
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Potential Categories of E-Iatrogenic Error

♦ Errors of Commission

♦ Errors of Omission or Transmission

♦ Clinical-Decision Support System Errors

♦ E-mail communication

Description

♦ Accessing wrong patient record or overwriting one patient’s information with that of another due to faulty patient identification management

♦ Loss/corruption of patient data due to data transmission technology issues (interface)

♦ Early indication from multiple sources is that medication error rate is decreased; however, full impact is unknown due to frequency of overrides

♦ Evolving area. Secure messaging may improve patient communication of clinically significant events

CAVEAT may create additional liability if emails are not monitored and followed up and if patients not carefully and clearly educated on appropriate use

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Metadata

♦ Metadata is structured information that describes, explains, locates, or otherwise makes it easier to retrieve, use, or manage an information resource. Metadata is often called data about data or information about information.

♦ Provides:

♦ Patient identity - data elements about a patient, which includes a patient’s full name, previous names with associated date ranges (as an optional element), date of birth, address, zip code and one type of patient identification (ID) data along with the origin of that ID (allows for data integration from disparate sources);

♦ 2. Provenance - data elements about the source of the clinical data, which provides information on the who, what, where and when and includes a tagged data element (TDE), a time stamp, and digital signatures used to ensure the data has not been altered since its creation; and

♦ 3. Privacy - data elements include a privacy policy pointer and content elements descriptions such as data type and sensitivity (allows setting of role based access)

http://www.healthit.gov
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Failure to Protect the Confidentiality Integrity and Availability of the Protected Health Information Stored in Your System

- Health Information Portability and Accountability Act (HIPAA)
  Enacted 1996
  Final Privacy Rule 2000
  Final Security Rule 2003
  - Business Associate Agreements, Notice of Privacy Practices
  Enacted 2009
- HITECH Final Omnibus Rule
  Issued January 2013
  Effective March 2013
  Compliance Date September 23, 2013

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Failure to Protect the Confidentiality Integrity and Availability of the Protected Health Information Stored in Your System

- HITECH Final Omnibus Rule Changes:
  - New Requirements for Covered Entities
  - Business Associate Definition Expanded to include those with Opportunity to Access PHI (implicates Cloud vendors)
  - Business Associate Obligations Apply Directly to All Business Associates
  - Business Associates Needs BAA with Downstream Subcontractors
  - Considers Mobile Technology
  - Breach redefined to Create Rebuttable Presumption of Breach
    - Acquisition or disclosure of unsecured PHI in a manner not permitted by Law is PRESUMED to be a breach until rebutted by demonstration of low probability that PHI compromised
  - Applicable Penalties Increased Across All Categories
    - Were $100 - $25,000 per category
    - Now 100 - $1.5M per category
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Review
Your Policy That Defines the Legal Health Record For Your Practice
- Individually identifiable data, stored on any medium, collected and directly used in documenting healthcare or health status.
- Business record is the record that will be disclosed upon request.
- May include source data (telemetry strips, etc.) or Records from other providers used for evaluation and/or treatment of the patient

Ensure That Policy and Procedure Exist for Managing Your Legal Health Record
- Media for generating and maintaining (Electronic, Hybrid)
- Standards for maintaining confidentiality, including data access, and release
- Content matrix plus rules for creating, modifying and adding addenda
- Authentication & Completion
- Security and Retention
- Downtime, Back-up, Disaster Recovery

Ensure That You are Following Your Policies and Procedures and That You Can Produce Your Legal Health Record as Defined in Your Policy and Procedures.

LEGAL HEALTH RECORD: Definition and Standards

LEGAL HEALTH RECORD: Definition and Standards DEVELOPING YOUR STRATEGY & Tool Kit Diane Premeau, MBA, MCIS, RHIA, RHIT, CHP, A.C.E. http://www.ihs.gov/california/assets/Final/GPRA/BP2012-LegalHealthRecord-Premeau.pdf

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Legal Health Record and Designated Record Set Resources
- AHIMA. "Fundamentals of the Legal Health Record and Designated Record Set." Journal of AHIMA 82, no. 2 (February 2011): expanded online version.
- Legal Electronic Health Record Policy Template. www.AHIMA.org Body Of Knowledge
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QUESTIONS???

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