ELECTRONIC HEALTHCARE RECORDS: RISKS AND REWARDS

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Overview

1. Introduction
   ◦ Use and Cost
   ◦ Dueling Systems
   ◦ Regulatory Oversight

2. Functions

3. Risk Factors

4. Malpractice & Liability Impact

5. Top Ten Benefits & Risks

EHR–EMR USE

A. “Meaningful use”: $27 billion available
   ◦ Physician Workflow Study: most physicians satisfied with EMR systems
   ◦ National Ambulatory Medical Care Study:
     • 2011: 74% of CHC have EMR
     • 2011: 55% of physician practices have basic EMR

B. Implementation cost/time
   ◦ Physicians complain about lack of data entry skills
   ◦ Systems devote $$ to training/assistance

C. Vendor Explosion: Over 675 vendors in US
   ◦ ONC top performers: KLAS Report 2011
     • Athenahealth: best for 11–75 users
     • Greenway Medical Technologies: 6–25 users
     • eClinical Works: 26–100 users
     • EPIC: > 100 users
   ◦ FQHCs work with eClinical & EPIC

D. Did you know–50% of systems sold are replacements??
   ◦ Service/update issues
   ◦ Group consolidation under health care reform
   ◦ Allscripts, GE Healthcare & McKesson most likely to be replaced

E. Regulatory Requirements
   ◦ ARRA: 2009–$19 bill for HIT–computerize health records by 2014
   ◦ HIPAA–HITECH
   ◦ CMS claim payment requirements
What is the “Good Housekeeping” Seal of Approval?

- Certification of EHR systems
  - ONC (Office of the National Coordinator) certification is basic
    - Does not evaluate usability, financial viability of company or strength of implementation and training
    - Most 2011 vendors can pass certification
  - CCHIT (Certification Commission for Health Information Technology) certification more comprehensive
    - Only 10% of 2011 vendors can pass this certification
    - Includes interoperability, security/audit functions and core + specialty features
    - Still no direct inspection–testing over 1 day
EMR Functions

A. Objective documentation of patient encounters
   ◦ Medical-legal necessity
   ◦ Immunization records, vital signs
   ◦ Telephone calls/requests
   ◦ Continuity of care over time

B. Data Repository
   ◦ Diagnostic testing
   ◦ Referrals/consultations
   ◦ Hospital admissions, ED visits

C. CPOE & E-Prescribing

D. Decision support—”alerts”/hard-stops based on clinical guidelines

E. Administration
   ◦ Billing/coding
   ◦ Consent/authorizations
   ◦ Audit/peer review
   ◦ Medical-legal support
F. Up Next: Patient Portals

- www.HealthIT.gov—video link
- ONC: recent conference was consumer directed
  - Encourages public use of technology to interact with providers and manage healthcare conditions & information
  - Did you know?? HIPAA data breaches -> significant penalties and corrective action plans by OCR
    - Phoenix Cardiac Surgery: 2-site cardiac surgery practice
      - Transmission of ePHI from e-mail account to employees personal e-mail accounts
      - Posting of ePHI to publicly accessible Internet calendar
      - No employee training on privacy/security policies
      - No privacy/security officer; no risk assessment, no BAAs
      - $100,000.00 penalty & CAP
G. Mobile Devices?

- Many considerations
  - security/encryption
  - apps and vulnerability to hacking
  - ownership of devices
  - variety of devices
- Convenience vs security
- ONC: seminar on mobile device issues
  - Message: It can be done!
Ohio Malpractice Update

- Ohio Dept. of Insurance Closed Claims
  - Claims down 41% between 2005–2010
  - Costs down $100 mill between 2005 – 2010
- Most claims: Internal Medicine
  - Failure to treat
  - Delay in treatment
  - Improper treatment
- Location of claim: Operating room
  - Office practice close second
- Clinic claims – 30 in claim review
  - Avg. indemnity: $32,891.00
- FTCA Trends: Birth injuries & diagnostic errors
  - HRSA data–FTCA claims rising
CNA Healthpro Claims Study
- 1998 – 2008
- No CRNA/CNMW
- No specific analysis of EMR impact

Most claims: Adult/Geriatric & Ped/Neo NPs
Location: Office & Urgent Care
Cause: Infection/sepsis → death
Avg. indemnity: $318,150.00
Liability Impact

- Malpractice cases generally down, but....
  - Risk of malpractice INCREASES during initial EMR implementation
    - “Learning curve” for physicians/providers
    - Computer errors/mistakes not recognized
    - System crashes—safety net???
    - Interfaces for dueling systems

- Post-implementation...
  - < transcription errors
  - < provider – provider communication
  - < duplication of diagnostic testing
  - > perpetuation of incorrect information; “cut/paste”
  - > metadata and audit functions establish/refute liability
Closed claims review
- 1 state examined data from 1995–2007
- Found rate of claims w/ EMR was lower than w/o
- Increased patient safety??

PIAA study demonstrated telephone–related claims cost $71.8 mill (2007)
- Inadequate information by phone
- Mismanagement of multiple calls
- Lesson: Similar problems could arise w/ EMR & e-mails through patient portals
New claims beyond malpractice

- Fraud/abuse—documented care not really delivered
- Vendor design/implementation
  - Med management—auto renewal/cancellation functions not reviewed
  - Recent med conditions not updated—no alert flag
  - No claim against EMR provider for third-party claim
- HIPAA privacy/security breaches
  - Pictures from EMR posted on social media sites
  - Incomplete copy of EMR provided; another patient’s data included
  - OCR investigation and civil/criminal litigation
Liability Impact, cont’d.

- Malpractice
  - Failure to update current clinical info
  - Failure to update current clinical guidelines
  - Override defaults w/o justification
    - Example: drug order despite allergy
  - Retained versions of documentation
    - Example: OV for infant w/ fever; documentation added 3 days later to reflect discussion w/ parent re: instructions to call back–go to ED
    - Audit trail exposes timing
Risk Management/Loss Prevention

- On the front end
  - Due diligence/research on systems to meet current and future EMR needs
  - Not just a cost decision—70% cost overruns
    - Cheap+fast+easy = better??? Not HIT
    - Certification—just the beginning!
    - Functionality checklist—current and future
    - Gradual implementation
    - Internal champions for user training
    - Interface requirements—who are your partners?
  - EMR should be part of overall strategy
Loss Prevention, cont’d.

- The Standard of Care & EMR
  - Clinical Practice Guidelines—developed by professional societies, state/federal entities
    - Not “cook–book” medicine
    - Objective, sound, reliable
  - Few exist concerning EMR/HIT
    - User problems are good source of information
    - Audit trails reveal issues w/ usability, problems w/ interfaces and/or display modality
    - Adverse event data can result in retrospective review, improvements and monitoring for effectiveness
Loss Prevention, cont’d.

- **Risk Assessment**
  - Review your liability claims history & patient complaints
  - Compare with state/national trends:
    - Delay in diagnosis/treatment
    - Failure to follow-up on referrals/test results
    - Missing documentation
  - EMR can provide data and/or solutions

- **EMR Data Use**
  - Model for standard of care decision support
    - Example: critical lab results with no follow-up trends up
    - Take issue to QA Committee to examine under confidentiality
    - Identify standard of care for outcome: receiving/acting on results
      - Literature review, data support
    - Map current process for flow of test orders through results
    - Involve partners in care—labs, hospitals, EMR vendors
    - Implement changes to improve outcome; ie—interfaces
    - Audit/monitor whether changes are effective through QA
Reimbursement risks

- OIG Work Plan 2012 targets “copycat” charts
  - 9/24/12 letter from HHS/DOJ
- HHS/Medicare Contractors auditing
  - “Cloned” documentation is a problem
  - Misrepresentation of medical necessity
  - Cutting/pasting information forward does not demonstrate unique care that patient receives

Recommendation: Read & edit for accuracy before you sign
Risk Financing: The Big Picture

- Important step in loss prevention/mitigation
- Identify “big, bad” losses at high level: “Black Swan”
  - Drill down; how likely is it that the event will occur?
  - What will occurrence cause? What is the estimated cost?
- Examine insurance coverage for all potential Black Swans
  - Example: System crash:
    - What would happen? Data loss, business interruption, IT system damage
    - What causes this to happen–can we predict how often?
    - How can we protect our center? Insurance program–CGL; contract with IT vendor for support/expenses
    - Are there exposures to our financial position? Look at deductible–do you “self-insure” and reserve?
- Are there additional commercial programs available?
  - Cyber liability insurance is new–forms are more comprehensive
- What other strategies can mitigate this loss?
  - Safety net–data recovery/restoration
  - Emergency/disaster drills –> quicker resolution through tested recovery plans
Review of Benefits and Risks: Popp’s Top 10

- Benefit
  - Legibility
  - E&M coding
  - Templates
  - “Normal” defaults
  - Time stamp/audit trail
  - Algorithms
  - Efficiency
  - Med mgmt.
  - Data entry at OV
  - Remote access

- Risk
  - “Texting” speech
  - Drag forward/fraud
  - Cut/paste errors
  - Errors on exam
  - Pre-charting
  - Not current
  - < Productivity
  - Auto-fill errors
  - Poor communication
  - Privacy/security
6 Golden Rules

1. Use your EMR to proactively identify sources of possible claims AND retroactively to investigate claims already in existence
   - Program flaws in EMR systems must be improved
   - CPOE: check default fields in prescribing modules
   - Interfaces with hospital EMR system can conflict
   - Compliance audits for “copy-cat” charts

2. Identify “experts” in your CHC who can assist w/ questions
   - Can be internal or external
   - Scribes or “Dragon”??

3. Make sure that you have a Litigation Hold policy and process in place for known claims and adverse events which may develop into claims
   - FTCA/DOJ requires Lit Hold when claims are reported
   - Have legal counsel experienced with EMR
4. Use your Quality Improvement/Assurance Committee to identify and work through clinical care issues

- In Ohio, peer review committee documents and proceedings are confidential
  - ORC 2305.251, .252
  - ORC 2305.253; Incident report protection
- Use EMR to support provider scope of practice
  - Example: Nurse practitioners cannot delegate med administration to MA per Ohio NPA
5. LEVEL to improve communication w/ EMR
   ◦ L: let patient look;
   ◦ E: eye contact
   ◦ V: value computer
   ◦ E: explain
   ◦ L: log off

6. Review each outside EMR request
   ◦ Standard process with administrative oversight
   ◦ Remember to check for paper records
   ◦ Audit requested? Check w/ IT provider
   ◦ Questions? Consult legal counsel
Resources

- Ozeran, L., M.D.; Anderson, M.; “Do EHRs Increase Liability” (copy provided with authors’ consent)
- HHS/DOJ Letter to Providers–9/24/12 (copy provided)