EMR Challenges and Opportunities

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Reduce Distractions. Improve Outcomes.

Disclosures

Ann Carter has no relevant financial relationships to disclose.

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The information presented at this program and in the program materials is for general educational purposes only and is in no way intended to serve as medical or legal advice. For advice on handling specific medical/legal problems, always consult with an attorney or your risk management staff.

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Handouts

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Objectives

At the end of the presentation, the participant will be able to:

- Understand EMR technologies, limitations, risks, and benefits.
- Identify potential HIPAA violations with an EMR.
- Review strategies for reducing risk, and improving communication and documentation.

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The Medical Record – Friend or Foe

- The medical record can be your best friend or your worst enemy
- A malpractice case boils down to this – who will the jury believe?

Source: John West, "Risk Management: Legal Issues in Documentation," The Risk Management and Patient Safety Institute (The RM&PSI), PowerPoint presentation, March 1, 2007.

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Clinical Purposes of Documentation

- Planning the course of treatment
- Care and treatment
- Communication among caregivers

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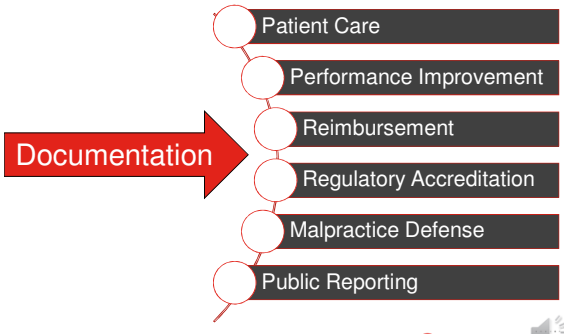
Documentation – At the Center of it All!



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The Electronic Medical Record (EMR)

- The patient record.
- Any information flowing into the record from other sources (cardiology, oncology, etc.)
- Emails, texts, chats, blogs, patient portals.
- Medical device downloads (EKGs and EEGs).
- IT servers, and audit trails.
- Billing information, including notes in the billing system.

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Advantages of EMRs

- Increases efficiency, data is readily available to others
- Improves quality and accuracy
- All information is available in one location
- Reduces the risk of misinterpretation
- Immediate availability of Labs, EKGs, Diagnostics
- Entries are dated, timed and authenticated
- Legible
- Reduces medication errors
- Less likely that records can be tampered with due to legal lock safeguards and access to an audit trail
- BUT – THERE ARE DISADVANTAGES

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How Attorneys Use Charting Failures to Support Medical Malpractice Actions

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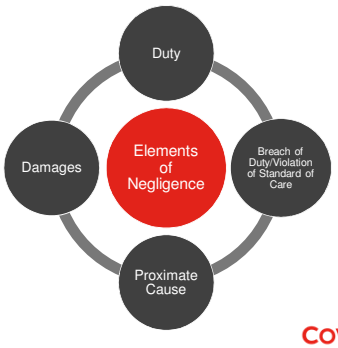
The Four Elements of Negligence



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EMRs Are Changing The Standard of Care

- Like any technology, the EMR can impose different responsibilities on health care providers:
  - Heightened duty to follow-up on test results.
  - More providers see the chart = more potential defendants.
  - Increased liability to all providers that can access the EMR.
  - Increased communication expectations – especially patient handoffs during transitions in care.
  - Expectation to use clinical decision support tools.

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Medical-Legal Importance

When care is in question…

If it *is not* in the patient's record, the record becomes a tool for the plaintiff:

- Plaintiff attorney may establish/infer negligence or discredit the record.
- A jury may decide care/treatment did not happen.
- Quality/credibility of providers in question.
- Disjointed healthcare team who lack communication and coordination.
- Standard of care not met.

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EHR Charting Issues and Strategies

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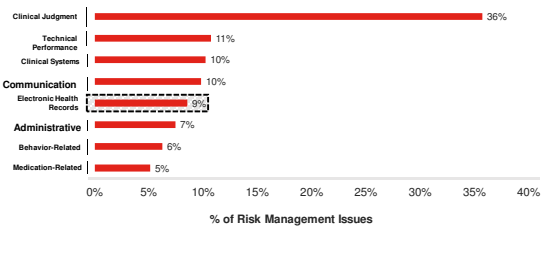
Top Risk Management Categories



Selection: N=11,499 risk issues on closed PL claims from 2015-2019
Footnote: A claim can have more than one risk management issue.

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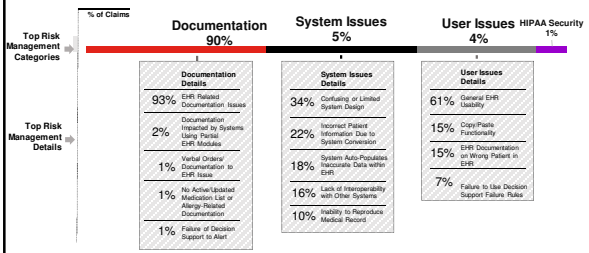
Top Risk Management Issues - Electronic Health Record



Selection N=982 risk issues, closed PL claims from 2016-2019 with an Electronic Health Record risk issue
Footnote: A claim can have more than one risk management issue

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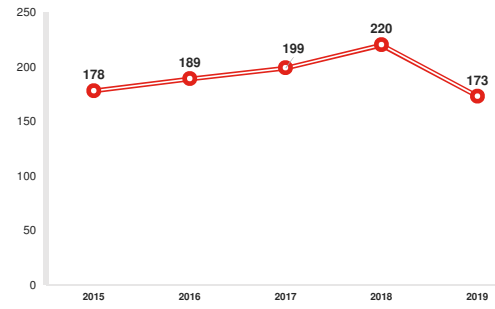
Claims by Closed Year



Selection: N=959 closed PL claims from 2015-2019 with an Electronic Health Records risk issue

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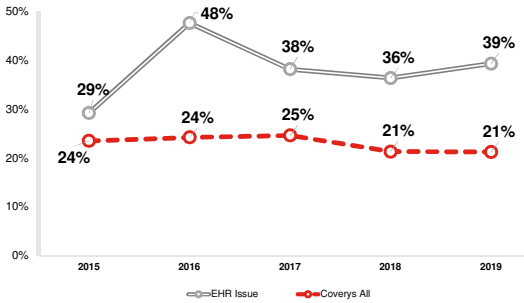
Percentage of Claims Closed with Indemnity Payment



Selection: N=959 closed PL claims from 2015-2019 with an Electronic Health Records risk issue

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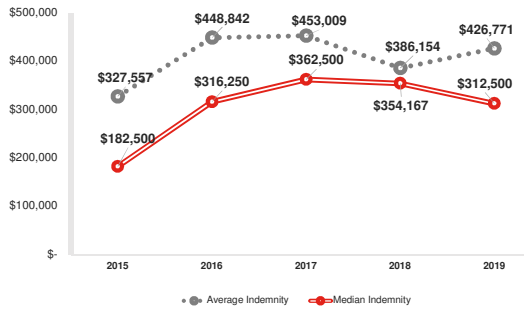
Average vs. Median Paid Indemnity



Selection: N=959 closed PL claims from 2015-2019 with an Electronic Health Records risk issue

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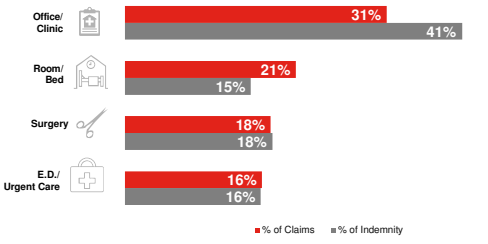
Top Locations



Selection: N=953 closed PL claims from 2015-2019 with an Electronic Health Records risk issue

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EMR Risk Issues

- Documentation "tampering" or "spoliation" (inadvertent or intentional)
- HIPAA Violations
- Copy and Paste" functionality (cloning, auto recall, carrying forward)
- Wrong patient/provider entries (multiple records open at one time)
- Drop down menus
- Customizing templates rather than using standard templates
- Addendums & Corrections
- Metadata and audit trails

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Documentation "Tampering" or "Spoliation"

- Erroneous entries – correcting documentation errors (Do we need to document "error" or draw line/initial errors?)
- Late entries – Do we note "late entry?"
- Deleting entries – careless destruction or "tampering" with relevant evidence (audit trail - key piece of evidence)
- Modifying records – HIPAA violation?

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Most Common HIPAA Violations

- **Snooping on Healthcare Records**
- Failure to Perform an Organization-Wide Risk Analysis
- Failure to Manage Security Risks / Lack of a Risk Management Process
- Failure to Enter into a HIPAA-Compliant Business Associate Agreement
- **Insufficient ePHI Access Controls**
- **Failure to Use Encryption or an Equivalent Measure to Safeguard ePHI on Portable Devices**
- Exceeding the 60-Day Deadline for Issuing Breach Notifications
- **Impermissible Disclosures of Protected Health Information**

Source: The HIPAA Journal. *The Most Common HIPAA Violations You Should Be Aware Of*, April 29, 2019.

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Most Common HIPAA Violations

- **Improper Disposal of PHI**
- **Denying Patients Access to Health Records/Exceeding Timescale for Providing Access**
- **Common HIPAA Violations by Healthcare Employees**
  - **Emailing ePHI to Personal Email Accounts and Removing PHI from a Healthcare Facility**
  - **Leaving Portable Electronic Devices and Paperwork Unattended**
  - **Releasing Patient Information to an Unauthorized Individual**
  - **Releasing Patient Information Without Authorization**
  - **Disclosures of PHI to Third Parties After the Expiration of an Authorization**
  - **Downloading PHI onto Unauthorized Devices**
  - **Providing Unauthorized Access to Medical Records**

Source: The HIPAA Journal, The Most Common HIPAA Violations You Should Be Aware Of, April 29, 2019.

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Copy and Paste Functionality

"The use of copy/paste functionality in EMRs should be permitted only in the presence of strong technical and administrative controls which include organizational policies and procedures, requirements for participation in user training and education, and ongoing monitoring."

American Health Information Management Association (AHIMA), *Appropriate Use of the Copy and Paste Functionality in Electronic Health Records*, March 17, 2014, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050621.pdf, 09/18/2015.

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Copy and Paste Functionality

Risks associated with copying and pasting information include the following:

- Copying and pasting inaccurate, duplicative, or outdated information
- Redundant information in the EMR, making it difficult to identify current information
- Inability to identify the original author or intent of the documentation
- Inability to identify when the entry was first created
- Inflated or fraudulent billing/Medicare claims/coding

The Joint Commission, *Preventing Copy-and-Paste Errors in EHRs*, November 14, 2014

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Strategy

- Copy and paste only according to practice policy, and that the policies are monitored, measured, and assessed.
- Make copy/paste entries identifiable.
- Ensure that copy and paste entries accurately reflect the patient's current status.
- Original source of copy/paste readily available.
- Train/educate staff on using copy/paste functionality.

www.ecri.org/Resources/HIT/HIT_Copy_Paste_Handout.pdf)

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Wrong Patient/Provider Entries & Strategies

- The "Imposter Patient" Issue
  - Validation of patient medical record/patient identifiers
  - Each EMR screen should reflect the patient's name – validate
- The "Imposter Provider" Issue
  - "That's not my note"
  - Challenges reliability of entire record
  - "Sloppy documentation" equates to "sloppy care"
  - Audit trails inaccurate

ALWAYS LOG ON AND OFF AS YOURSELF!

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Drop Down Menu Issues & Strategies

- Provide customized, not standardized, care.
- Know your default values. What does the system insert if you do not pick an option?
- Don't forget to unclick pre-populated fields. Breast exam normal, when no exam was performed.
- Do not pick "best option" that is "close enough." Use free text to customize if able.
- Be Alert: Easy to "be quick to click" on an incorrect option! Think twice, click once!

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Templates

- Auto generated/default
- Inability to discern between positive and pertinent negative findings
- Conflicting or contradictory assessments
- Non specific templates – user customizable
  - User is accustomed to checking a box when patient is known to have allergies which triggers an alert
  - Prior user customized a template and included allergy information in a problem list
  - Patient given medication to which he is allergic
- Form changes/updates – structured fields
- No designated place for signature or co-signature

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Strategy

- Check if template auto-generated before documenting
- Customize templates according to office/hospital policy
- Ensure that pertinent information is prominently displayed – test results that require intervention, allergies and medication sensitivities, patient reactions to treatments and medications
- Question unfamiliar templates – are they updated templates or incorrect templates
- If the template does not provide signature and co-signature lines, obtain instruction on where these should be placed

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Ignoring Alerts & Clinical Decision Support

- "Alert Fatigue" is a natural human reaction – if EVERYTHING is an "alert" then NOTHING is an "alert."
  - Creates a danger that care providers may ignore, disregard, override, or disable alerts, warnings, and reminders
  - Embedded practice guidelines such as drug allergy alerts, drug interaction alerts, or test result tags such as "L" next to a low laboratory value.
    - Example – Nurse ignores alert in Computerized Physician Order Entry System indicating potential drug interaction that results in an adverse event
  - Clinical Decision Support (CDS) alerts are often ignored

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Strategy

- Do not disable, silence, override or lower alerts or alarms
- Rectify a disabled, silenced or lowered alert or alarm or notify someone is authorized to do so
- Practitioners should document the reason why they overrode the CDS alert

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Addendums & Corrections

- Seldom are helpful
- Should be authorized by risk management and, when appropriate, in collaboration with legal counsel
- Should be done accordingly with office policy
- Only include needed information
  - Often after an adverse outcome they are overly – explanatory and self-serving
- If done incorrectly, can be perceived as fraudulent
  - This turns a malpractice case into a criminal case

Sarah Sheber, "New Toolkit Provides Guidelines for HER Amendments," Journal of AHIMA, August 28, 2012, http://journal.ahima.org/2012/08/29/new-toolkit-provides-guidelines-for-ehr-amendments/, accessed Nov. 2017

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Metadata & Audit Trails-Telling the Story

Metadata/audit trails are designed to track:

- Users who document in the record
- Time and date of access/note creation
- Identity of those who accessed/documented
- Where (what terminal) the access occurred
- Deletions and changes and by whom
- Length of time which record was accessed

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Metadata & Audit Trails

- **Metadata** is NOT part of the patient's "legal medical record"
  - But it is documentation that **is** available
  - It **may** be requested by auditors, the facility/employer, and a plaintiff attorney
  - It can and **will** be "Exhibit A" if it reflects a "smoking gun"
- Audit Trails:
  - Tell us when information was available
  - Tell us who accessed the information
  - Provide evidence of actions, if any, were taken
  - May raise question as to whether the care provided met a reasonable standard of care

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8. Metadata & Audit Trails

Death by a Thousand Clicks: Where Electronic Health Records Went Wrong

Consider the case of 5-year-old Uriah R. Roach, who fractured and cut his finger on Oct. 2, 2014, when it was accidentally slammed in a door at school. Five days later, an operation to repair the damage went awry, and he suffered permanent brain damage, apparently due to an anesthesia problem. The Epic electronic file had been accessed more than 76,000 times during the 22 days the boy was in the hospital, and a lawsuit brought by his parents contended that numerous entries had been "corrected, altered, modified and possibly deleted after an unexpected outcome during the induction of anesthesia." The hospital denied wrongdoing.

The case settled in November 2016, and the terms are confidential.

http://fortune.com/longform/medical-records/

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Documentation – A Communication Tool

- Documentation is ***Critical***
  - You are not likely to remember specifics about care years later.
  - Your charting is a reflection of the type of care you provide.
- Be specific and factual when documenting
- Ensure that evidence-based practices, protocols, guidelines and order sets are built into the system.

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Strategies to Enhance Documentation for the Team

- Print off and audit your records.
- Think about how late entries look.
- Know what your electronic records look like for a deposition or in trial.
- Collaborate with your IT department to identify opportunities to enhance the EMR system.

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Departing Thoughts

- A good record defends itself and those who put entries in it.
- A chart is a witness that never dies or never lies.

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